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In the

Supreme Court of the United States

October Term, 1997

DIANNE L. SHEA, Individually and as Trustee for the Heirs of Patrick Joseph Shea, Decedent; Individually and Derivatively on Behalf of Participants in the Seagate Group Health Plan,

Petitioner,

v.

SIDNEY ESENSTEN; JEFFREY A. ARENSON; FAMILY MEDICAL CLINIC, P.A., n/k/a FAIRVIEW CLINICS, a Minnesota Non-Profit Corporation; and MEDICA, a Minnesota Non-Profit Corporation,

Respondents.

PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. IS THE QUALITY OF CARE THAT AN HMO DELIVERS A FEDERALLY REGULATED "BENEFIT" OF AN ERISA "PLAN", THEREBY PREEMPTING STATE TORT, MALPRACTICE, AND HEALTH INSURANCE LAW?

2. IF THE QUALITY OF CARE IS A "BENEFIT" OF AN ERISA "PLAN", THEN IS A CIVIL ACTION UNDER ERISA § 502 TO RECOVER THE DENIAL OF THAT "BENEFIT" COMPENSABLE WITH A MONEY DAMAGES AWARD?

LIST OF PARTIES

Petitioner Dianne L. Shea ("Mrs. Shea"), plaintiff in the trial court and appellant in the United States Court of Appeals for the Eighth Circuit, seeks a remedy for the death of her husband. This tragedy, she alleges, was caused by the malpractice and ethical violations of the Respondent doctors and clinic and by undisclosed financial incentives against necessary and competent medical care created and enforced by Respondent Medica, an HMO.

Respondents Sidney Esensten ("Esensten") and Jeffrey A. Arenson ("Arenson") were Mr. Shea's treating primary care physicians who refused to refer Mr. Shea to a cardiologist and who actively dissuaded him from seeking out cardiology consult on his own. They practice through their clinic, the Respondent Family Medical Clinic (the "Clinic").

Respondent Medica is an HMO licensed by the State of Minnesota. As an employee of Seagate, Mr. Shea was covered by Medica, and the Respondent doctors and Clinic were authorized by Medica to treat Mr. Shea pursuant to a managed care contract. Medica also was delegated certain administrative functions by the Seagate Group Health Plan, a welfare benefit plan governed by ERISA.

The caption does not list Fairview as a party. Fairview is a party to a related proceeding created by the District Court's dismissal of Medica and remand of the remaining State law claims to State court. Fairview is a system of hospitals and clinics that was subsequently added as a party defendant to those State proceedings, on the theory that it owned and controlled the Respondent Clinic. Thereafter, Fairview removed the case back to U.S. District Court while the appeal of Medica's preemption and dismissal was pending before the Eighth Circuit. The new federal action was assigned a separate file number (3-96-406).

Also not listed in the caption is the Secretary of the United States Department of Labor, who intervened in the

Eighth Circuit as amicus curiae to support Mrs. Shea's petition for rehearing.

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OPINION BELOW

The Eighth Circuit's opinion is reprinted in the appendix ("App."), page 1A, infra, and is published as Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997).

JURISDICTION

The opinion to be reviewed was filed by a three-judge panel of the United States Court of Appeals for the Eighth Circuit on February 26, 1997. Petitioner Dianne L. Shea ("Mrs. Shea") filed a timely petition for rehearing by the panel and for rehearing en banc on March 12, 1997. The Eighth Circuit denied rehearing and rehearing en banc in a one-page order dated May 6, 1997. App. 38A. Pursuant to Fed. R. App. P. 41(a), the appellate court's mandate consists of the opinion and is effective seven days from denial of rehearing, i.e., May 13, 1997.

For the purposes of review in this Court, Mrs. Shea's petition for rehearing by the panel (which was combined with an en banc petition per Eighth Circuit practice, see Eighth Circuit Rules 35A(c)(4), 40A(2)) stayed the ninety-day period in which to petition for certiorari. That ninety-day period runs from issuance of the May 6, 1997 order denying rehearing, not from the May 13, 1997 issuance of the mandate. Supreme Court Rule 13.3. Hence this petition was due August 4, 1997 and was timely filed by that date.

This Court enjoys jurisdiction to review the opinion and mandate of the Eighth Circuit pursuant to 28 U.S.C. § 1254(1).

Because the United States Department of Labor intervened as amicus curiae in support of Mrs. Shea's petition for rehearing, this petition has been served on the United States Department of Labor and on the Solicitor General of the United States. Supreme Court Rule 29.4(a).

STATUTORY PROVISIONS AT ISSUE

29 U.S.C. §§ 1144(a); 1144(b)(1),(2); 1144(c); 1002(1); 1132(a)(1) (ERISA §§ 514, 3(1), 502(A)(1)). See App. 39A.

STATEMENT OF THE CASE

Petitioner Dianne L. Shea ("Mrs. Shea"), the plaintiff-appellant below, is the widow of Patrick Joseph Shea ("Mr. Shea"), who died of cardiac arrest at the age of 40 on March 5, 1993. Original Complaint ¶¶ 1, 52-57. She is the mother of two children, who were age 14 and 12 at the time of Mr. Shea's death. Id. ¶¶ 5, 11-12. In June of 1994, Mrs. Shea commenced in Minnesota's Hennepin County District Court a medical malpractice action against the Respondent doctors, Sidney Esensten ("Esensten") and Jeffrey A. Arenson ("Arenson"), and their clinic, the Family Medical Clinic, P.A. (the "Clinic"). In the several years leading up to his death, Mr. Shea had repeatedly visited these defendants with concerns about his strong family history of heart disease, high cholesterol, and chest pain that in one instance required hospitalization during a 1992 business trip to Thailand. Original Complaint ¶¶ 1, 34-51. These defendants not only ruled out a heart condition on the basis of notoriously unreliable treadmill tests, but actively dissuaded Mr. Shea from seeking out a second opinion from a cardiologist. Id. When he experienced chest pains on the afternoon of his death, Mr. Shea drove to the Clinic to show the doctors his symptoms, instead of stopping at a hospital. He pulled over the side of the road and died. Id. at ¶¶ 52-57.

The defendant doctors and Clinic were paid by Mr. Shea through the "Medica Primary" health insurance he had obtained through an ERISA employee benefit plan offered by his employer, Seagate Technology. Original Complaint ¶¶ 9. Mrs. Shea added Medica, an HMO[1], to the action on the

[1] Under Minnesota law an HMO must be nonprofit. Minn. Stat. §

theory that the "managed care" incentives against cardiology referrals, which Medica had negotiated with the defendant doctors and Clinic (a) tortiously interfered with the doctor-patient relationship; and (b) were fraudulent because they should have been disclosed under State insurance law and common law. Id. at ¶¶ 71-91.

The unredacted sections of the Clinic contracts, included in the District Court record in the Fourth Affidavit of Corey J. Ayling and reprinted in the Appellant's Supplemental Appendix filed under seal with the Eighth Circuit ("Eighth Cir. Supp. App."), demonstrate the specifics of the managed care incentives. Eighth Cir. Supp. App. 52-73 (redacted version of Two Pool Primary Care Provider Participant Agreement Between Share [Medica's predecessor] and Family Medical Clinic, Ltd, 5/1/91); 276-83 (unredacted pages of same). Seagate paid premium dollars to Medica for the Medica Primary health insurance accepted by Mr. Shea, its employee and participant in Seagate's Group Health Plan. Medica immediately pocketed 15% for itself. Then it deposited 31% in a "PCPCF" fund used to pay the Clinic for primary care. Any surplus left over in that fund is paid to the Clinic on a monthly basis. However, fees of specialists who are referred business by the Clinic (acting as "gatekeeper") are also paid out of that same PCPCF fund. Therefore, the more referrals, the less money there is left over to pay the Clinic for providing primary care to Medica Primary patients. If a modest number of referrals is made, this would decrease the amount of surplus paid to the Clinic; if still more referrals are

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62D.03 Subd. 1; 62D.12 Subd. 9. This, of course, does not prevent Medica from doing business with decidedly for-profit vendors, or prevent those for-profit entities from making a healthy return on such business. There is some indication in the record of a close relationship between Medica and United HealthCare Corporation, a multibillion dollar for-profit corporation based in Minneapolis. For instance, the lifeblood of Medica is its health "plans". Yet, it is United HealthCare Corporation that owns the copyright to the Medica Primary "plan." See Eighth Cir. Supp. App. 98.

made, then the Clinic may not even be paid for the billed value of its primary care services. Eighth Cir. Supp. App. 52-73, 276-83.

The remaining 54% of premium dollars is deposited in an "ICF" fund used to pay the in-patient costs associated with hospitalization and specialist care. That is, the surgeon's fee is paid out of the PCPCF fund; but the larger costs of hospitalization are paid out of the ICF fund. If referrals for in-patient care are not made, then a surplus results. That surplus is split 65% for the Clinic and 35% for Medica. If too many referrals for in-patient care are made creating a deficit in the ICF fund, then the Clinic can be held responsible for 50% of the deficit. Thus, the Clinic bets that it won't make so many expensive referrals as to create deficits that it will have to fund -- and bets that it will be stingy enough in referrals to create a lucrative bonus from surplus. Neither this bet, nor the similar bet made via the PCPCF Fund, was disclosed to Mr. Shea. Eighth Cir. Supp. App. 52-73, 276-83; Original Complaint ¶ 74; First Amended Complaint ¶ 78.[2]

In addition to functioning as an HMO and health insurer, accountable to the Minnesota Department of Health via the State HMO statutes, see Minn. Stat. § 62D, Medica also functioned as an administrator of the Seagate Group Health Plan, a welfare benefit plan governed by ERISA. "In connection with Seagate's Plan, Medica provides administrative services as part of its managed care product, including but not limited to claims handling, quality assurance

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[2] There is some confusion in the record on the distribution of dollars as between the PCPCF Fund and the ICF Fund. The quoted percentages reflect those noted in the 1991 contract for non-Medicare patients. Medicare patients have a different breakdown -- i.e., 49% for the PCPCF Fund and 36% for the ICF Fund. Eighth Cir. Supp. App. 280. In addition, these allocations between the funds for Medicare and non-Medicare patients are reversed on an earlier version of the contract by handwritten notation -- i.e., non-Medicare members have 49% allocated PCPCF Fund and 36% for the ICF Fund. It is not clear whether this same change was intended for the 1991 version of the contract.

and utilization review." Helen Zwak's Affidavit in Support of Defendant Medica's Memorandum of Law in Opposition to Plaintiff's Motion to Remand to State Court (filed by Medica on 9/20/94) (reprinted in Appellant's Eighth Circuit Appendix ("Eighth Cir. App.") at 146.

Mrs. Zwak's second affidavit dated May 11, 1995, Eighth Cir. App. 213, attaches the Medica Primary Master Group Contract dated January 1, 1993 and in effect on the date of Mr. Shea's death. The contract is three pages long, and sketches out the one-year term of the contract, the premium schedule, and some miscellaneous items. Appendix A to the contract specifies eligibility requirements for Medica Primary insurance -- i.e., the employee must be full time, new hires are eligible, dependents of a certain age are eligible, and the employee's spouse is eligible. Eighth Cir. App. 219-20. Rules for "enrollment" are set forth, as are events that terminate coverage (e.g., employer terminated the master contract, employee stops paying his or her own contribution toward premium, spouse divorces, etc.). Eighth Cir. App. 221.

Also attached to the Master Group Contract was a "Medica Primary Certificate" that explains the terms of the health insurance. These terms include a "consumer bill of rights" required by Minnesota's HMO law. Eight Cir. App. 224-25; Minn. Stat. § 62D.07 Subd. 3. These include "the right to receive information about your health problems, treatment alternatives, and associated risks. This is to assure that you can make an informed choice about your health care." Eighth Cir. App. 225. The certificate elsewhere explains that the insured, or "member", must select a "Primary Care Office." Eighth Cir. App. 250 at § 9.2. This primary care office "shall be responsible for the coordination of all Health Services rendered to the Member and for ensuring continuity of care." Medica warranted that, subject to the terms of the certificate, "a Member is entitled to Coverage for Health Services described in Section 10 of this Certificate if

such Health Services are Medically Necessary and are provided by or under the direction of the Member's Primary Care Office." Eighth Cir. App. 250 at § 9.1. Nowhere did the certificate explain that Mr. Shea's primary care doctor would be fined by Medica for referring the patient to a cardiologist and be paid a bonus for declining the make the same referral.

On July 19, 1994, Medica removed the case to the United States District Court for the District of Minnesota. Medica claimed that the issue of its disclosure obligations to Mr. Shea "related to" an ERISA plan -- viz., the Seagate Group Health Plan -- and therefore was preempted by ERISA. The District Court agreed, denying Mrs. Shea's motion to remand in an order filed October 14, 1994. See Appendix hereto ("App.") 1A. Ordinarily, a federal preemption defense will not provide the basis for federal removal jurisdiction because it does not appear on the face of a well-pleaded complaint. Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 63 (1987). However, the District Court cited to an exception to the "well-pleaded complaint rule" where the asserted State action conflicts with a federal statutory scheme. This is the "complete preemption" doctrine, which holds that Congress can so "completely pre-empt[ ] a particular area of [of law] that any civil complaint raising this select group of claims is necessarily federal in character." Metropolitan Life, 481 U.S. at 63-64.

Medica then moved to dismiss the entire action against it on the merits as "preempted." Mrs. Shea's position was that to the extent State theories did relate to an ERISA plan and were preempted, ERISA itself substitutes a remedy. In short, preemption of State law remedies did not remove any chance for some remedy.

The District Court dismissed the complaint with leave to amend to cure two deficiencies: (1) Mrs. Shea had to sue on behalf of the ERISA plan; and (2) she had to plead facts from which it could be inferred that Medica was an ERISA fiduciary. Transcript of April 14, 1995 Hearing at p. 27; see also App. 9A. On April 24, 1995, Mrs. Shea filed a First

Amended Complaint that included a Count III on behalf of the Seagate Plan seeking equitable relief against Medica for fraudulent nondisclosure of physician incentives that constituted a breach of fiduciary duty. Counts IV and V were styled as direct claims (as opposed to claims on behalf of the Plan) and alleged breach of fiduciary duty and an arbitrary and capricious denial of benefits, respectively.

In an order filed November 15, 1995, the District Court granted Medica's motion to dismiss the First Amended Complaint with prejudice, reasoning that disclosures regarding financial arrangements with doctors were not "facts affecting the interests of beneficiaries." App. 25A. Because the subjects of the requested disclosure were found immaterial as a matter of law, the District Court dismissed the action and remanded the remainder of the case (consisting of the malpractice and related counts against the Defendant doctors and Clinic) to State court.

On remand, the Hennepin County District Court granted Plaintiff's motion to add as a party defendant Fairview (the large institution that controls the Defendant Clinic and doctors) and for leave to allege punitive damages. The punitive damages claim was premised on the contention that the doctors (and the institutions through which they practice -- Fairview and the Clinic) owed an ethical duty to disclose a fundamental conflict of interest. The patient should have known that when his doctors were dissuading him from seeking out specialist care, those doctors had a financial stake in discouraging specialist care that would reduce bonuses paid to their Clinic and that could even result in the Clinic being forced to pay 50% of the in-patient costs out of its own pocket. In support of this position, Mrs. Shea filed an affidavit from Dr. Mark Siegler, the Director of the Center for Clinical Medical Ethics at the University of Chicago. The Hennepin County District Court granted Mrs. Shea leave to add Fairview and to pursue punitive damages, observing:

> The facts as presented by Plaintiff portray a particularly unconscionable course of conduct by all Defendants. Not coincidentally, this scenario brings to life many patient's fears of managed health care.

In May of 1996, the doctors and their employing institutions removed the case back to federal court on ERISA grounds. Mrs. Shea unsuccessfully contended that unlike Medica, these doctors and institutions were not even arguably acting as ERISA fiduciaries. The doctors and institutions argued that they were aiding and abetting an ERISA fiduciary (Medica) in administering an ERISA plan and, therefore, the case against them was preempted. Because of this removal, the entire case is back in federal court, although the second removal was assigned a new file number as a separate case (File No. 3-96-406) and has never been before the Eighth Circuit. Because of this procedural anomaly, Dr. Siegler's affidavit, the ruling of the State court adding Fairview and allowing a claim of punitive damages, and Fairview's removal petition are not a part of the Eighth Circuit record, but are properly the subject of judicial notice. It is contemplated that the District Court will consolidate the proceedings against Medica (District Court File No. 3-94-1173) with the proceedings removed by Fairview (No. 3-96-406).

In the meantime, Mrs. Shea filed a notice of appeal on November 30, 1995, invoking the Eighth Circuit's jurisdiction under 28 U.S.C. § 1291. The Eighth Circuit's opinion released on February 26, 1997 held that the State tort claims against Medica were preempted by ERISA. App. 31A; Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997). It reversed the District Court's dismissal of the action on the merits. The panel reasoned that the disclosures at issue were material and actionable under ERISA.

On March 12, 1997, Mrs. Shea petitioned for rehearing by the panel and for rehearing en banc. The petition was directed at the preemption issue and cited a number of recent

Supreme Court decisions indicating a dramatic reduction in the preemptive sweep of ERISA. The United States Department of Labor filed an amicus brief in support of Mrs. Shea's position. The petition was denied by order dated May 6, 1997. App. 38A. This petition for a writ of certiorari was filed within 90 days thereafter. Supreme Court Rule 13.1.

At the rehearing stage, Medica raised for the first time a jurisdictional challenge to further appellate consideration of the preemption issue. In particular, Medica contended that Mrs. Shea failed to appeal the District Court's order of April 24, 1995 dismissing as preempted Mrs. Shea's State law claims against Medica. This jurisdictional challenge is without basis because, pursuant to Eighth Circuit practice, Mrs. Shea filed an "Appellant's Form A" that specifically stated Mrs. Shea's intent to appeal "[w]hether ERISA preempts a state tort claim against an ERISA fiduciary for tortious interference with the doctor patient relationship and for fraud." App. 30A. This suffices to vest the appellate court, and ultimately this Court, with jurisdiction over the issue. Burgess v. Suzuki Motor Co., 71 F.3d 304, 306 (8th Cir. 1995) (in determining scope of appeal, court can rely both on the notice of appeal and on Form A); ELCA Enterprises, Inc. v. Sisco Equipment Rental & Sales, Inc., 53 F.3d 186, 188 (8th Cir. 1995) (timely filed Form A supplements and amends the notice of appeal and vests court with jurisdiction over matter raised therein).

Furthermore, Medica's responsive brief on the merits filed with the Eighth Circuit demonstrates that it clearly understood that the issue was before the Court. Medica itself designated the April 24, 1995 order in its statement of the Eighth Circuit's jurisdiction, identified separately in its statement of the issues the issue of whether the State claims were properly removed from the State court and the issue of whether the State claims were properly dismissed as preempted under ERISA § 514, and briefed each issue separately. Medica's Brief as Appellee, No. 95-4020, U.S.

Court of Appeals for the Eighth Circuit, Feb. 23, 1996, at pp. xii, xv, 39-49.

REASONS FOR GRANTING THE WRIT

When ERISA was passed in 1974, it was common for employers to offer health insurance to employees. In return for premiums that were generally paid by the employer, the health insurers paid for the employee's necessary medical expenses. The purpose of ERISA was to protect the employees, in response to the contemporaneous spectacular failures of some employers to fund fringe benefits, particularly pensions. Congress expressly intended to preserve the additional protections of State health insurance and tort law.

In the intervening quarter century, the health insurers have, through their HMO products, dramatically expanded their power to influence and control medical decisions. They have used the carrot and stick of financial incentives to doctors, and the doctors' need to maintain a steady stream of patients by posting "good" managed care statistics, to influence and ultimately corrupt the doctors' judgment. In the process, they have misused the ERISA statute, in particular its preemption provisions, to immunize themselves from legal accountability for the fatally poor medical care that sometimes results from this system.

In the 1990s some circuits have begun to define some limited means for holding HMOs accountable. The Second, Third, and Tenth Circuits have refused to preempt State medical malpractice claims that allege malpractice on the part of the HMO. However, even these circuits are divided as to their rationale, and all have placed substantial limits on the potential State tort liability of the HMO. In direct conflict with the law of the Second, Third, and Seventh Circuits, the Fifth Circuit has refused to hold HMOs liable for poor health care. The Eighth Circuit has also refused, but, in the case

decided below, has held that HMOs must affirmatively disclose physician incentives or face liability under ERISA on a breach of fiduciary duty theory.

This Court should grant certiorari to resolve this conflict among the circuits on a matter affecting the lives of the tens of millions of Americans covered by ERISA plans. The Court should resolve the conflict by building on its recent decisions criticizing the broad sweep of ERISA preemption adopted in past cases and focusing the inquiry on whether the preemption would serve the objectives of ERISA. This, in turn, requires preemption **and the substitution of an ERISA remedy** only to the extent that the health insurer actually acts as an ERISA plan administrator -- i.e., determines eligibility, calculates benefit levels, makes disbursements, monitors the availability of funds for benefit payments, and keeps records that comply with ERISA reporting requirements. When the HMO signs up doctors and negotiates incentive contracts, it is acting as a health insurer. The poor health care that results from those arrangements is a health insurance matter subject to State tort laws that survive ERISA's preemptive sweep.

The status of plan administrator is not a shield to avoid accountability. Indeed, that status is an acceptance of additional accountability as a fiduciary under ERISA. But when not acting as a plan administrator -- which is the case a great deal of the time -- the health insurer is accountable under State law. This Court should resolve an inter-circuit conflict by granting certiorari and by ending the health insurance industry's misuse of plan administrator status and the complexities of ERISA preemption doctrine to evade accountability.

I. THE DUAL ROLE OF HMOs AS HEALTH INSURERS AND PLAN ADMINISTRATORS.

Private health insurance began in the 1920s as a cushion against unexpected hospital bills. Only a few companies

offered such insurance as a fringe benefit. Health insurance became a standard employee benefit in the years after World War II. See generally G. Anders, Health Against Wealth: HMOs and the Breakdown of Medical Trust 18-21 (1996). By 1974, health insurance and other employee benefits such as pension plans were sufficiently standard to merit congressional scrutiny and regulation via the passage of the ERISA statute. By 1982, Americans with private health insurance peaked at 188 million, dipping thereafter to 182.5 million in 1989. Id. at 22. In the meantime, spending on medical services climbed from 4% of the GNP in the late 1940s to 12% by the end of the 1980s -- i.e., over $600 billion annually. Id. at 19, 22.

The standard form of health insurance in effect at the time of ERISA's passage in 1974 was fee-for-service. Employees visited their doctor; the insurance company paid the bill; the employer paid the insurance company via premiums and surcharges. Managed care and HMOs were in their infancy. The major pioneers included Kaiser Permanente, created on the West Coast during World War II to serve workers at the Kaiser shipyards and steel mills. Kaiser built its own hospitals and clinics and employed its own physicians full time. However, by the mid-1960s less than 2% of the population belonged to such HMOs. Even as recently as 1985, only 10% of the population was covered by HMOs. Membership since then has exploded. Id. at 27-34.

Before ERISA, private health insurance companies sold a lot of insurance that covered a lot of workers. After ERISA, private health insurance companies sold a lot of insurance that covered a lot of workers. The only difference was that after ERISA, the benefit package created by the employer became a separate legal entity called an ERISA plan. Technically, the health insurers sold their products to the ERISA plan, though the employer was the real party in interest during bargaining given that the employer funded the plan and appointed the plan's trustees.

Essentially, ERISA held employers to their promises when they offered employees fringe benefits. See generally SUBCOMM. ON LABOR OF THE SELECT COMM. ON LABOR AND PUB. WELFARE, 94TH CONG., 2D SESS., LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (Comm. Print 1976). It was not enough to say that employees would retire with a pension or would have their doctors' bills paid. After 1974, this fringe benefit had to be adequately funded, eligibility for such benefits had to be fairly decided, reports had to be filed, and the benefits had to be managed by fiduciaries answerable to the employees and to the U.S. Department of Labor. This system created some administrative headaches that smart health insurance companies who wanted to stay competitive were happy to take off the employer's hands. Health insurance companies offered to take on some of the roles of a plan administrator. They wrote, enforced, and administered eligibility criteria for employees who wished to be covered by the health plan. And they did what they always did: sold particular brands of health insurance to the employer, albeit now through the employer's ERISA plan.

It is this dual role of health insurers that is critical to Mrs. Shea's position and the Department of Labor's position urged in its amicus brief below. Health insurers spend a great deal of their time selling health insurance and acting as health insurers regulated by State law. They can also sweeten the package offered to employer-created ERISA plans by taking on some administrative duties that are regulated by ERISA. Mrs. Shea's position is that this new-found ERISA fiduciary status does not insulate the health insurer from liability for delivering poor health insurance and poor health care.

II. TO DETERMINE THE SCOPE OF ERISA PREEMPTION OF CLAIMS OF POOR MEDICAL CARE, THE COURT MUST DETERMINE WHETHER THE QUALITY OF CARE DELIVERED IS A "BENEFIT" OF AN ERISA "PLAN."

ERISA preempts State laws, including State tort suits, that "relate to" an ERISA plan. 29 U.S.C. § 1144(a); ERISA § 514; New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645, 115 S. Ct. 1671, 1675 (1995). This Court has rejected a broad literal interpretation of this "related to" language, given that logically relations stop nowhere. Id., 115 S. Ct. at 1677. "We simply must go beyond the unhelpful text and frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive". Id.

Preemption stops short of "any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A); ERISA § 514(b)(2)(A). However, States cannot evade preemption by regulations that essentially deem the ERISA plan to be insurance companies subject to State insurance law. 29 U.S.C. § 1144(b)(2)(B); ERISA § 514(b)(2)(B). Because the "historic police powers of the State include the regulation of matters of health and safety", those seeking to preempt the State's exercise of such powers "bear the considerable burden of overcoming 'the starting presumption that Congress does not intent to supplant state law.' Travelers, 514 U.S., at 654...." DeBuono v. NYSA-ILA Medical and Clinical Services Fund, 117 S. Ct. 1747, 1751 (1997). ERISA does not preempt a "'myriad state laws' of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of the governing statute." DeBuono, 117 S. Ct. at 1752.

Congress did intend to supplant State laws, even traditional ones, that regulated the administration of an ERISA welfare benefit plan. Congress intended "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government ..., [and to prevent] the potential for conflict in substantive law ... requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." Travelers, 115 S. Ct. at 1677 (quoting Ingersoll Rand Co. v. McClendon, 498 U.S. 133, 142 (1990)). This case concerns the effect of HMO incentive contracts with doctors on the quality of health care. Mrs. Shea claims that such arrangements undermine the quality of care in a way that is actionable in tort. In particular, Mrs. Shea claims that the contracts tortiously interfere in the doctor-patient relationship and, because they are undisclosed by HMOs who have a duty of disclosure under State insurance and tort law, are fraudulent.

The key inquiry is whether contracts between an HMO and doctors are part and parcel of the administration of an ERISA plan. If so, then ERISA preempts State law claims that challenge the quality of care resulting from such contracts. If not, then the State law claims can proceed as the stuff of State health insurance and tort law of general applicability which, while imposing some burdens on the administration of ERISA plans, do not "relate to" them within the meaning of ERISA § 514.

III. THE CIRCUITS ARE HOPELESSLY DIVIDED AND CONFUSED ON WHETHER AND TO WHAT EXTENT ERISA PREEMPTS TORT CLAIMS CONCERNING THE QUALITY OF CARE DELIVERED BY AN HMO.

The Fifth and Eighth Circuits have held that ERISA preempts State tort suits challenging the quality of care delivered by an HMO or other health insurer. In Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir.), cert. denied, 506 U.S. 1033 (1992), the employer's health plan required the covered employee to obtain advance approval of an overnight hospital stay ("precertification") from United Healthcare, the plan's cost containment consultant.[3] United Healthcare denied precertification to a pregnant employee deemed by her doctor to be in a category of high risk pregnancy. While at home, the employee lost her unborn child and sued United Healthcare for wrongful death. Citing Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41 (1987), for the proposition that ERISA preempts State-law tort claims for improper processing of benefits offered by an ERISA plan, the Fifth Circuit preempted the wrongful death action. Although United Healthcare may have made a negligent medical decision, it did so "in the context of making a determination about the availability of benefits under the [ERISA welfare] plan." Corcoran, 965 F.2d at 1331. The court noted that this left the plaintiff with no remedy and called for a reevaluation of ERISA by Congress in light of the post-ERISA growth of managed care. Id. at 1333, 1338-39.

The Eighth Circuit followed Corcoran in Kuhl v. Lincoln National Health Plan, 999 F.2d 298 (8th Cir. 1993), cert. denied, 510 U.S. 1045 (1994). The decedent in Kuhl was covered by an HMO that refused to precertify heart surgery at

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[3] This is the same United Healthcare that owns the copyright to Medica's health "plans." See supra note 1.

a hospital outside its service area. As a proximate result of the ensuing delay, he died. His widow commenced a State-law action for tortious interference in the doctor-patient relationship, medical malpractice, and breach of contract. Citing Pilot Life, the Eighth Circuit found such precertification decisions to be benefit plan administration decisions preempted by ERISA. In its decision below in the case at bar, the Eighth Circuit continued to follow Kuhl but held that ERISA itself provides a remedy in such situations. Finding Medica to be an administrator of Mr. Shea's health plan, and finding that "claims of misconduct against the administrator of an employer's health plan fall comfortably within ERISA's broad preemption provision", the court preempted Mrs. Shea's tortious interference and fraud claims. However, it rejected the notion that Mrs. Shea was left with absolutely no remedy. Having conceded that it was engaged in ERISA plan administration in choosing not to disclose the challenged physician incentives, Medica opened itself to liability as an ERISA fiduciary who breached its duties in failing to make a material disclosure to its plan participants. App. 31A; Shea v. Esensten, 107 F.3d 625, 628-29 (8th Cir. 1997).

The problem with these rulings is their easy assumption that medical decisions by plan administrators are necessarily the stuff of "plan administration." That Medica is in some sense an ERISA plan administrator does not mean it is always acting in that capacity. As noted above, HMOs act in a dual capacity. To preempt a claim against an HMO it must first be shown that the claim concerns the HMO's conduct in its capacity as an ERISA plan administrator, not as a health insurer. An HMO cannot use its plan administrator status as a shield of immunity in all contexts -- any more than an attorney can use her attorney status to cloak all communications, even those made outside the confines of the attorney-client relationship. It is vital, then, that courts define just what "plan administration" is and base their preemption

decisions on whether the HMO in the particular circumstance at bar was acting as a "plan administrator."

Other circuits have refused to preempt State tort suits challenging the quality of care. The rationale for these decisions varies, however, and the tort suits may be subject to a number of restrictions. Perhaps the leading case is Dukes v. U.S. Healthcare, 57 F.3d 350 (3d Cir. 1995). There, the patient died as a result of high blood sugar levels, which allegedly would have or could have been diagnosed through a timely blood test. His widow commenced a State court malpractice suit. She added the HMO on a respondeat superior or ostensible agency theory (i.e., the patient reasonably believes that he is being treated by medical employees of the HMO) and on a direct negligence theory (the HMO was negligent in selecting, retaining, screening, monitoring, and evaluating personnel who provided the medical services). In a companion case, Mr. and Mrs. Visconti sued the same HMO on similar ostensible agency and direct negligence theories arising from their obstetrician's failure to diagnose preeclampsia, which killed their unborn daughter.

The Third Circuit noted that a preemption defense ordinarily does not provide the basis for removal jurisdiction. Pursuant to the "well pleaded complaint" rule, the basis for federal jurisdiction must appear on the face of the complaint, not in an affirmative defense of the answer. An exception to this rule is the "complete preemption doctrine" -- that is, "Congress may so completely preempt a particular area that any civil complaint raising this select group of claims is necessarily federal in character." Metropolitan Life, 481 U.S. at 63-64. In the Third Circuit's view, the dispositive provision of ERISA was § 502, which defines the ERISA claims that completely preempt overlapping State claims, not ERISA § 514, which defines the full scope of ERISA preemption. "State law claims which fall outside of the scope of § 502, even if preempted by § 514(a) are still governed by the well-

pleaded complaint rule and, therefore, are not removable under the complete-preemption principles established in Metropolitan Life." Dukes, 57 F.3d at 355. "Put another way, every state claim completely preempted by § 502 is, a fortiori, related to ERISA, but not every state claim related to ERISA under § 514 is completely preempted." Lancaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, 958 F. Supp. 1137, 1144 (E.D. Va. 1997).

ERISA § 502(a)(1)(B) authorizes an action "to recover benefits due ... under the terms of [the] plan, to enforce ... rights under the terms of the plan, or to clarify ... rights to future benefits under the terms of the plan." The Third Circuit reasoned that complaints about the quality of care were not a claim for benefits. The HMO did not deny any "benefits" in the sense of refusing to authorize or pay for certain tests or procedures. It just delivered shoddy medical care. "Quality control of benefits, such as the health care benefits provided here, is a field traditionally occupied by state regulation and we interpret the silence of Congress as reflecting an intent that it remain such." Dukes, 57 F.3d at 357.

While a step in the right direction, the Third Circuit's reasoning left a number of questions unanswered and provides little guidance for future cases. The court noted that the quality of medical care provided may be so low as to constitute a denial of any benefits at all -- thereby justifying ERISA preemption. Dukes, 57 F.3d at 358. In other words, the poorer its job performance, the more likely the HMO will be rewarded with ERISA preemption and the substitution of an inadequate ERISA remedy. In addition, the Third Circuit invited the HMOs to evade its holding in the future by defining a certain level of quality of service as one of the "benefits" delivered under the "plan." Id. All of which demonstrates once again that the common fallacy of ERISA preemption jurisprudence is the failure of the courts to define in the first instance just what a "benefit" is and just what a

"plan" is. Certiorari is necessary to better define these terms and to clarify the law in this area. The Department of Labor urged in both Dukes, 57 F.3d at 356, and in the case below that the ERISA "benefit" is simply membership in the HMO and that the ERISA "plan" is the terms, conditions, and procedures for signing up for that membership. The terms and operation of the HMO, and the quality of care delivered, may be a health "plan" in the colloquial sense, but not in the ERISA sense. This is the stuff of State health insurance and tort law and is not preempted by ERISA.

The Tenth Circuit has followed the Third Circuit's lead in refusing to preempt a vicarious medical malpractice claim against an HMO, though its reasoning differed. Pacificare of Oklahoma, Inc. v. Burrage, 59 F.3d 151 (10th Cir. 1995). There, the widow alleged medical malpractice on the part of the primary care physician; the HMO was added as vicariously liable for the misconduct of the doctor as its alleged agent. The widow further alleged direct liability on the part of the HMO for loss of consortium and wrongful death. Unlike the Third Circuit, the Tenth Circuit reasoned that a complaint about the "quality" of health benefits would be preempted by ERISA. However, the claim focused not on any "benefit" but on the doctor-patient relationship, something traditionally left to the States and not preempted by ERISA. Quoting a district court opinion, the Tenth Circuit reasoned: "when an HMO plan elects to directly provide medical services or leads a participant to reasonably believe that it has, rather than simply arranging and paying for treatment, a vicarious liability medical malpractice claim based on substandard treatment by an agent of the HMO is not preempted." Pacificare, 59 F.3d at 155. The court further made the pragmatic observation that "[j]ust as ERISA does not preempt the malpractice claim against the doctor, it should not preempt the vicarious liability claim against the HMO if the HMO has held out the doctor as its agent." Id.

Nonetheless, the Tenth Circuit found direct claims of negligence against the HMO to be preempted. "A loss of consortium claim against an HMO alleging negligent or fraudulent administration of the plan is preempted by ERISA." Id. at 155.

Although the subject of some criticism, see Comment, Loosening ERISA's Preemptive Grip of Medical Malpractice Claims: A Response to Pacificare of Oklahoma v. Burrage, 80 Minn. L. Rev. 1545 (1996), the functional and pragmatic approach of the Tenth Circuit conforms to the spirit of the Supreme Court's recent preemption decisions starting with Travelers, 115 S.Ct. at 1677. It is difficult to imagine that Congress intended to preempt State medical malpractice and tort law; States have always licensed and regulated the practice of medicine and there is not a shred of evidence in the legislative history that Congress sought to federalize this area. As a consequence, there is considerable force to the logic that any claim merely derivative of the patient's medical malpractice claim against his doctor is not preempted.

Like Dukes, Pacificare ultimately does little to clarify and settle this area of law. "Benefit", "plan", and "plan administration" are left undefined. Yet, all preemption logic must ultimately follow from how those terms are defined. If, for instance, the "benefit" is defined as the assurance of competent, medically necessary care, and the "plan" is defined to include the managed care devices through which this benefit is delivered, then there may well be grounds to preempt the vicarious liability claim against the HMO. And if the doctor is simply an employee or ostensible employee completely controlled by the HMO, it can be argued that the malpractice claim against the doctor is preempted as well. The absurdity of this latter result, which no court has accepted, counsels toward a careful and more limited definition of "benefit" and "plan".

Two circuits essentially follow the Third Circuit rule enunciated in Dukes. In a decision decided before Dukes and

cited in Dukes, the Second Circuit held that negligent supervision of a psychotherapist who committed malpractice is not the kind of benefit or breach of fiduciary duty claim that would require complete preemption under ERISA § 502. Lupo v. Human Affairs International, Inc., 28 F.3d 269 (2d Cir. 1994). The defendant in that case, however, was not an HMO or other health insurer. The Defendant corporation employed a negligent psychotherapist and had contracted with the plan to provide psychiatric services. Similarly, the Seventh Circuit cited and adopted Dukes in holding that ERISA does not preempt a medical malpractice claim against the HMO and plan administrator who designated the negligent doctor as the care provider. Rice v. Panchal, 65 F.3d 637 (7th Cir. 1995). The liability theory was one of respondeat superior.

Certiorari is appropriate "[w]hen a United States Court of appeals has rendered a decision in conflict with the decision of another United States court of appeals on the same matter." Supreme Court Rule 10.1(a). Here the Eighth Circuit has joined the Fifth Circuit in preempting State law claims about the quality of care delivered by an HMO that would not be preempted by the Second, Third, Seventh, and Tenth Circuits. Furthermore, the reasoning and approach of all circuits, even those which reach the same result, is so varied as to require an exercise of this Court's supervisory jurisdiction.

IV. THE COURT SHOULD GRANT CERTIORARI AND HOLD THAT A PLAN ADMINISTRATOR IS ACCOUNTABLE UNDER ERISA WHEN IT ACTS AS A PLAN ADMINISTRATOR AND ACCOUNTABLE UNDER STATE LAW WHEN IT ACTS AS A HEALTH INSURER OR PROVIDER.

The Court should grant certiorari to resolve this conflict among the circuits. "[T]he split among courts", one district

court observed, "exemplifies the difficulty [of] this preemption issue." Haas v. Group Health Plan, Inc., 875 F. Supp. 544, 547 (S.D. Ill. 1994). With its decision in Travelers, the Supreme Court has announced a pragmatic and functional approach to ERISA preemption that promises to resolve what has been a recurring issue of great complexity and confusion. See Fisk, The Last Article About the Language of ERISA Preemption? A Case Study of the Failure of Textualism, 33 HARV. J. LEGIS. 35 (1996).

The root of the problem is something missing from the decisions below and not sufficiently developed in Travelers and its progeny: a workable and practical definition of "plan administration" and "benefit." When an area has become as mired in confusion as that of ERISA preemption, the root cause is usually because the courts have lost sight of first principles. Here, the first principles to be established are (1) what was intended to be accomplished in ERISA; and (2) given that, how, then, should the Court define "plan administration" and "benefit"? Once that is done, the rationale and results of preemption analysis naturally and easily follow.

Travelers and its progeny address the first issue. The general purpose of ERISA was to ensure prudent and responsible fund management so that employers delivered on their promises to provide fringe benefits.

> "In enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds. To that end, it established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management

by the plan administrator." [Massachusetts v. Morash, 490 U.S. 107] at 115 [(1989)].

California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc., 117 S. Ct. 832, 838-39 (1997). The purpose of ERISA's preemption clause was "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government ..., [and to prevent] the potential for conflict in substantive law ... requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." Travelers, 115 S. Ct. at 1677 (quoting Ingersoll Rand, 498 U.S. at 142).

As a consequence, State laws that literally and directly "relate" to an ERISA plan survive preemption so long as they don't dictate how plans must be structured and benefits calculated. Compare Travelers, 115 S. Ct. 1671 (State surcharge may indirectly influence how ERISA plans are structured but is not preempted because it does not bind plan administrators to any particular choice), Dillingham, 117 S. Ct. 832 (economic incentive to hire apprentices created by California prevailing wage law does not bind or practically require benefit plans to have a particular apprentice program; therefore, State law survives ERISA preemption), and DeBuono, 117 S. Ct. 1747 (1997) (direct tax on medical centers owned by ERISA fund does not dictate plan structure or calculation of benefits and is a tax generally applicable to the whole industry; therefore, it is not preempted); with Boggs v. Boggs, 117 S. Ct. 1754 (1997) (State community property laws that undermine surviving spouse's pension benefits in favor of decedent's heirs and legatees dictates the structuring of benefits in a manner contrary to that required by Congress and is preempted), and FMC Corp. v. Holliday, 498 U.S. 52 (1990) (Pennsylvania law preventing ERISA plan from

subrogating itself to beneficiary's tort recovery dictates plan structure and is preempted).

This case, and medical malpractice cases in general, present this Court with an opportunity to finish the job started in Travelers. Having held that the intent of ERISA requires preemption analysis to focus on the effect of the State law in dictating plan structure and benefit calculation, this case squarely presents the Court with the need to define "plan structure" and "benefit calculation" in a more rigorous manner. Is the quality of care delivered by an HMO or other health insurer part of "plan administration" or the kind of "plan benefit" such that it is preemptively and exclusively regulated by ERISA? The Court's answer to this question will allow the lower courts to resolve future preemption cases easily and clearly.

There is much to be said for the Department of Labor's proposed resolution of this issue. In its amicus brief in support of rehearing, the Department of Labor urged a narrow definition of "plan" and "benefit." The "plan" here was the terms and conditions of obtaining the "benefit" of membership in the HMO. The terms of the HMO itself, its provider contracts, and the care delivered as a result are all part and parcel of State health insurance and tort law. These are matters historically regulated by the States and were not intended to be preempted by ERISA.

Even a broader definition of "plan" and "benefit" would be a pragmatic solution that would compel reversing the result below. Congress has never marshalled the votes necessary to pass national health insurance and to federalize medicine. Although there is some evidence that back in 1974, proponents of ERISA viewed ERISA as a prelude to national health insurance, see Fisk, supra, 33 HARV. J. LEGIS. at 57, there is no basis to conclude that Congress intended ERISA to preempt State health insurance or medical malpractice law. All that ERISA federalized was the ability to specify what kind of health care the employer would pay for and how it

would fund those commitments. This supplies a workable definition of "plan administration."

Here, Seagate set up a health plan. It agreed that employees could at certain times through certain procedures enroll in this health plan. It agreed to pay certain premiums. It delegated to Medica the task of explaining what kind of care would be covered and determining coverage in particular cases. These are plan administration functions governed exclusively by ERISA.

Medica, however, functioned in a separate and distinct capacity as a health insurer and provider. It provided care via networks and procedures that included managed care incentives that penalized doctors for making necessary referrals to specialists. In Mr. Shea's case, this resulted in the delivery of a poor and unacceptable quality of care for which Medica should be held accountable. This is not "plan administration." Creating secret financial incentives that work against the ethical practice of medicine is not "plan administration", but is, instead, part and parcel of the very large area of medicine and health insurance that ERISA left untouched in anticipation of future legislation that would nationalize health care -- and which never passed. Mrs. Shea's State law claims that Medica tortiously interfered in the doctor-patient relationship and fraudulently failed to disclose these incentives in its capacity as a health insurer should not have been preempted.[4]

Such a definition of "plan" and "benefit" compels the conclusion that HMOs act largely as health insurers and are

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[4] The result does not change if Seagate and Medica chose to rewrite plan documents to provide the "benefit" of HMO-quality health care, with disputes about quality being determined administratively pursuant to a severe limitation in damages. It is Congress and the court, not Seagate and Medica, that determine what an ERISA benefit is. An ERISA benefit is the entitlement to have certain kinds of health care paid. The quality of the care delivered, and its consistency with State law, are matters of State health insurance and medical malpractice law.

subject to the State laws that govern such conduct. This comports with common sense -- after all, Medica calls itself a "health maintenance organization" not a "fringe benefit plan consultant." But to the extent Medica does act as an ERISA plan administrator, this results in additional liability under ERISA. That is, the cost of Medica's choice to function in a dual capacity is dual liability. To the extent Medica acts in an ERISA capacity by enrolling employees in Medica Primary and explaining to them what will be paid for, it incurs a fiduciary duty under ERISA to make full disclosure of the financial incentives that may undercut the ability of plan participants to obtain specialist care. But in setting up the provider networks in the first instance and in running these networks without disclosing incentives to the insured, it is acting in a health insurance capacity and has duties of disclosure under State law.

The industry has hitherto turned this dual capacity to its advantage with the following syllogism: (1) The same company functions as plan administrator and as health insurer; (2) the health insurance function is "related to" the plan administration function; (3) therefore both functions are preempted by ERISA. Travelers, however, rejected such a facile reliance on the breadth of the "related to" language in favor of a pragmatic construction that gives effect to ERISA's essential purposes. One of those purposes was to preserve the States' role as the primary regulator of health insurance. Therefore, the appropriate result that vindicates ERISA's purposes is to apply ERISA where the HMO acts as a plan administrator and to apply State law where it acts as a health insurer. As a consequence, Mrs. Shea can pursue a dual recovery under ERISA for Medica's nondisclosures in its capacity as plan administrator and under State law for Medica's nondisclosures and tortious interference as a health insurer.

Finally, it should be noted that narrower holdings are available to preserve Mrs. Shea's State claims, and, while not

the preferable result here, Mrs. Shea does reserve all rights to urge such narrower holdings. In particular, while it can be argued that by reason of the "deemer" clause, 29 U.S.C. § 1144(b)(2)(B), certain health insurance regulations are preempted, there is no question that the States regulate health provider functions. When an HMO contracts with a doctor in a way that affects the doctor's medical decisions, the HMO is functioning as a health provider. Congress never intended to preempt State claims governing the health provider function. In short, one possible favorable result for Mrs. Shea would be to build on the Tenth Circuit's holding that claims against HMOs, which are merely derivative of claims against doctors, are not preempted. Pacificare, 59 F.3d at 151. Another possible holding is to distinguish between medical malpractice claims and the kind of fraud and tortious interference claims urged by Mrs. Shea. The medical ethics and doctor-patient issues that form the root of Mrs. Shea's claims are unquestionably matters of State regulation untouched by ERISA -- and present a stronger case against preemption than simple malpractice claims which, it can be argued, are open to some preemption as health insurance laws that run afoul of the "deemer" clause.

V. ALTERNATIVELY, IF QUALITY OF CARE IS AN ERISA "BENEFIT" DELIVERED BY ERISA "PLAN ADMINISTRATION", THEN AN ACTION UNDER ERISA FOR RECOVERY OF THAT "BENEFIT" MUST INCLUDE COMPENSATORY DAMAGES.

If the Court were to hold that the quality of care is part of ERISA plan administration, then it should clarify what ERISA remedy should be substituted for the medical malpractice remedies it preempts. If the quality of care is an ERISA "benefit", then the plan member has the right to sue to "recover benefits due him." ERISA § 502(a)(1)(B). The

"benefit" due is a higher quality of care, in this case a timely referral (and a "medically necessary" referral, to use the HMOs' language) to a cardiologist that would have saved Pat Shea's life. The recovery of that "benefit due" would be a damages award representing the value of the life that the "plan" implicitly promised to protect. In short, the cost of an expansive definition of "benefit" and "plan administration" is to expand the civil action permitted for recovery of "benefits" under ERISA § 502(a)(1)(B).

To be sure, this would mark an important development in ERISA law, particularly given the Court's refusal to allow money damages in analogous cases filed under ERISA § 502(a)(3). Mertens v. Hewitt Associates, 113 S. Ct. 2063 (1993).[5] But such a step would be the necessary and logical result of the expansive definition of "benefit" and "plan administration" urged by Respondents and adopted by the courts below. Perhaps the more prudent approach would be to reconcile ERISA law by adopting the narrower definition of "benefit" and "plan administration" urged by the Department of Labor and Mrs. Shea.

But the Court should make clear that the managed care industry cannot have it both ways -- as they so often have in misusing the ERISA statute for a quarter century. If expansive definitions of "benefit" and "plan administration" require preemption of State tort remedies, then those same expansive definitions must enlarge what is permitted to be recovered pursuant to a "benefits" recovery action under

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[5] Allowing money damages here could be reconciled with Mertens given the difference in statutory language between an action for recovery of benefits (ERISA § 502(a)(1)(B)) and an action to enjoin violations of the Act or for other equitable relief (ERISA § 502(a)(3)). Only the latter statute contains the phrase "equitable relief"; it was this statute that was reviewed in Mertens. The present case involves the former statute which contains no reference to "equitable" relief and which contains no other express statutory language that would necessarily preclude money damages for the value of the benefit foregone.

ERISA § 502(a)(1)(B). Either way, the time has come for an industry that dominates one-seventh of the nation's GNP to be held accountable when its actions cause death and human devastation.

CONCLUSION

The scope of ERISA preemption of State tort claims challenging the quality of care delivered by HMOs or other health insurers has divided the circuits, and even the rationale of circuits reaching similar results is so divergent as to make a mockery of Congress' goal to provide national and uniform law in this area. This case squarely presents the Court with an opportunity to clarify the first principles that underlie sound ERISA preemption analysis: the definition of ERISA "benefit" and "plan administration." Having clarified those first principles, ERISA preemption will be a more coherent area of law that will require less attention from this Court and from lower courts. The Court should therefore grant Mrs. Shea a writ of certiorari to the United States Court of Appeals for the Eighth Circuit.

Respectfully Submitted,

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Dated: August 4, 1997

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
FOURTH DIVISION

Dianne L. Shea,

Plaintiff,

Civ. No. 4-94-0610

v.

MEMORANDUM OPINION AND ORDER

Sidney Esensten; Jeffrey A. Arenson; Family Medical Clinic, P.A., N/K/A Fairview Clinics; and Medica,

Defendants.

Plaintiff Dianne Shea moves to remand this action to state court under 28 U.S.C. § 1447. Following her husband's death on March 5, 1993, plaintiff filed this action in Hennepin County District Court on June 30, 1994. The complaint named as defendants Doctors Sidney Esensten and Jeffrey Arenson; the Family Medical Clinic, where the two doctors practiced; and Medica, the health maintenance organization which administered the deceased's health plan. The complaint did not name the deceased's employer, Seagate Technology, which paid at least two-thirds of the of the deceased's Medica premiums.

Plaintiff alleges that the defendant doctors caused her husband's death by failing to refer him to a cardiologist and that Medica's undisclosed payment policies provided the doctors a financial disincentive to make referrals. All counts in the complaint are based on state law. The counts against

Medica are fraud, negligent misrepresentation, and tortious interference with the doctor-patient relationship and/or contract. Medica removed the case to this court under 28 U.S.C. § 1441 on July 17, 1994.

Plaintiff moves to remand the case on the basis that this court lacks subject matter jurisdiction. Because the parties are not diverse, federal question jurisdiction is the only possible basis for jurisdiction. 28 U.S.C. § 1331. Under the well-pleaded complaint rule, a defendant may generally remove a case only if the plaintiff's complaint includes a claim arising under federal law. Gully v. First National Bank, 299 U.S. 109 (1936). Even if the plaintiff only makes state law claims, however, a case may be removed if those claims "relate to" an employee welfare benefit plan under 29 U.S.C. § 1144(a) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, et. seq.[1] Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 63-64 (1987). Although the "related to" test is used to determine both removal jurisdiction and preemption, no issue of preemption is before the court at this time.

Plaintiff claims that her causes of action are not related to an ERISA plan. She argues first that Medica has not shown that the plan is governed by ERISA: "While, presumably, that test can be met in the case of the Seagate plan, it is the burden of the Defendants claiming federal jurisdiction to establish this." Plaintiff's Notice of Motion and Motion for Remand to State Court at 5. Based on the affidavit of Helen Zwak and the attached exhibits, however, Medica has demonstrated that

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[1] Section 1144(a) of ERISA reads as follows:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and are not exempt under section 1003(b) of this title.

29 U.S.C. 1144(a).

it was administering an employee welfare benefit program for Seagate. Seagate was engaged in commerce. 29 U.S.C. § 1003(a)(1). Further, the Medica plan provided ongoing medical benefits to employees, Seagate paid much of the cost, and none of the exceptions in 29 U.S.C. § 1003(b) apply. The plaintiff has not refuted any of Medica's proof regarding these facts. The plan Medica administered for Seagate is an ERISA employee benefit program.

Plaintiff next argues that the state law causes of action do not factually "relate to" an employee benefit plan under 29 U.S.C. § 1144(a). The Supreme Court has held that this section has an expansive sweep and that the relation between a state law and an employee benefit plan must be determined in a common sense fashion. Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41, 44-47 (1987). "[A] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 111 S.Ct. 478, 483 (1990). Where the existence of a plan is a critical factor in establishing liability under a state law, the necessary connection exists. Id. As the following analysis of the state law claims shows, all of plaintiff's counts against Medica would require reference to the employee benefit plan and are therefore "related to" it.

In the fraud and negligent misrepresentation counts, plaintiff alleges that Medica failed to disclose details of how the preferred providers under the plan are compensated. Specifically, Medica allegedly withholds fifteen percent of its payments to participating clinics until an annual audit assesses each clinic's average cost per patient. According to the plaintiff, if the average cost is too high, clinics are penalized. Doctors therefore have an incentive to keep costs low. Plaintiff claims that this structure should have been revealed to the deceased to inform his decision regarding the refusal to refer him to a cardiologist.

Many cases have found that similar claims were "related to" an employee benefit plan under ERISA. See, e.g., Stock v. Share, 18 F.3d 1419, 1422 (8th Cir. 1994) (misrepresentation and breach of contract claims); Hermann Hospital v. MEBA Medical and Ben. Plan, 845 F.2d 1286 (5th Cir. 1988) (fraud claim); Lea v. Republic Airlines, Inc., 903 F.2d 624 (9th Cir. 1990) (same); Cromwell v. Equicor-Equitable HCA Corp., 944 F.2d 1272 (6th Cir. 1991) (negligent misrepresentation); Straub v. Western Union Tel. Co., 851 F.2d 1262 (10th Cir. 1988) (same).

The misrepresentations alleged in this case have a connection to the plan. If the deceased had not enrolled in the Medica plan, Medica would have had no duty whatsoever to the deceased, let alone the alleged duty to disclose to him its financial arrangements with its health care providers. If the misrepresentation counts were allowed to proceed, it could be necessary to determine the benefits to which the deceased was entitled under the plan, the benefits he might have been promised, and the benefits he actually received. Furthermore, the deceased consulted the defendant doctors because they were associated with the plan. Finally, if the state law causes of action were allowed to go forward and were successful, the disclosure requirements for plan administrators like Medica would be affected if they attempted to avoid similar liability under state law in the future. These causes of action could not be resolved without reference to the employee benefit plan under ERISA.

For similar reasons, plaintiff's state law claim for interference with the doctor-patient relationship and/or contract is related to the health plan. While the doctor-patient relationship generally is accorded a great deal of deference, the relationship in this case is a creature of the ERISA plan. Medica and its doctors enter into contracts to provide medical services to plan members. In fact, it would be impossible to administer a managed care plan without agreements between

the plan and its participating doctors regarding procedures and payment. If the state law counts were allowed to proceed, reference to the plan would be necessary during litigation to determine the relationships among Medica, its providers, the deceased, and the plan benefits. This is the basis of the plaintiff's interference claim so the count has the requisite connection to the plan to be "related to" it.

The leading case in the Eighth Circuit on tortious interference in this context, Kuhl v. Lincoln National Health Plan, 999 F.2d 298 (8th Cir. 1993), is helpful to consider. The Kuhl plaintiffs alleged that the health plan's delay in scheduling surgery caused the death of the insured. Id. at 300. The court held that their state law claim of tortious interference with the decedent's right to contract for medical care was preempted by ERISA. Id. at 302-03.[2] The principle appears applicable here also.

The conclusion that the plaintiff's counts against Medica are related to an ERISA plan is also supported by application of the six-factor test identified in Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital, Inc., 947 F.2d 1341, 1344-51 (8th Cir. 1991). First, although the state law claims do not appear to "negate a plan provision," they could have an

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[2] Other courts facing similar claims have reached the same conclusion. For example, in Rodriguez v. Pacificare of Texas, Inc., 980 F.2d 1014, 1016 (5th Cir. 1993), the plaintiff argued under state law that the defendant health maintenance organization's refusal to refer him to an orthopaedic specialist was a failure to "provide prompt and adequate medical coverage." The Fifth Circuit held that the plaintiff's state law claims were preempted by ERISA because "at bottom, [they] result from dissatisfaction over [the HMO's] handling of his medical claims." Id. at 1017. See also Tingey v. Pixley-Richards West, Inc., 953 F.2d 1124, 1131 (9th Cir. 1992) (finding interference with contract claim preempted because it "spring[s] from the handling and disposition of [plaintiff's] medical benefits insurance claim . . . . "); Maciosek v. Blue Cross & Blue Shield United of Wisconsin, 930 F.2d 536 (7th Cir. 1991) (tortious interference with doctor-patient relationship); Rollo v. Maxicare of Louisiana, Inc., 695 F.Supp. 245 (E.D.La. 1988) (same).

"impact on the plan's structure." Id. at 1345. If successful, the financial structure allegedly used by Medica to contain costs would be changed. Second and similarly, the state law claims could affect disclosure and referral arrangements between the plan and its members, who are primary ERISA entities. The plaintiff's attempt to isolate the relationship between Medica and its providers does not change the fact that the three causes of action under consideration ultimately affect the benefits and information Medica must provide. As the Seventh Circuit has noted, "[A]rtful pleading of a claim nominally under state law cannot prevent removal." Anderson v. Humana, Inc., 24 F.3d 889, 891 (7th Cir. 1994).

Third, success under Minnesota common law would have an impact on plan administration. Arkansas Blue Cross, 947 F.2d at 1346-48. For example, Medica and other plans might have different disclosure requirements in Minnesota than in other states or might be required to use markedly different financial arrangements with their providers. Fourth, success on the state law claims could have a significant economic impact on the plan. If the tortious interference claim were allowed to go forward, for instance, Medica might be less able to contain costs. Fifth, preemption of the state law claims seems consistent with other ERISA provisions. For example, 29 U.S.C. § 1132(a) provides for civil enforcement of claims involving rights and benefits under a plan, and § 1132(c) provides a remedy if a plan administrator fails to meet the ERISA disclosure requirements. Given the considerations under the first five factors, it is unnecessary to consider the sixth--the traditional state power factor--because the Court of Appeals has found it useful only in "borderline" cases. Id. at 1350. The six-factor test confirms the conclusion that the three common law counts against Medica are "related to" the ERISA plan.

Even if the claims are related to the ERISA plan, however, plaintiff argues they should be preserved by the

ERISA "savings clause," 29 U.S.C. § 1144(b)(2)(A), which states: "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance." The savings clause only applies to statutes which specifically regulate the insurance industry. Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41, 50 (1987); Baxter by and through Baxter v. Lynn, 886 F.2d 182, 185-86 (8th Cir. 1989). Plaintiff's claims are based, however, not on specific state statutes which regulate insurance, but on common law causes of action of general application.[3] Thus, the savings clause does not apply to the plaintiff's counts against Medica.

In summary, the plaintiff's three causes of action against defendant Medica are related to an employee benefit plan under ERISA. Further, the savings clause is not applicable to those common law counts. Therefore, there is federal question jurisdiction under 28 U.S.C. § 1331, and the case was properly removed.

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[3] In her Memorandum in Support of Motion for Remand to State Court ("Plaintiff's Memorandum"), the plaintiff argues for the first time that the common law causes of action were preserved under Minn. Stat. § 62D.12 Subd. 1. That statute does not appear to preserve common law causes of action; instead it merely references specific state statutes. The plaintiff has not pled any of the referenced statutes, and in fact argues that Medica "was subject to suit by insurance customers under the common law of the State." Plaintiff's Memorandum at 13. It is precisely those common law causes of action which are not aimed specifically at the insurance industry that are not preserved by the savings clause. The court therefore need not determine the relationship between the statutes referenced by § 62D.12 Subd. 1 and the savings clause.

ORDER

Accordingly, based upon the above, and all the files, records, and proceedings herein, IT IS HEREBY ORDERED that plaintiff's motion to remand to state court is denied.

Date: 10/12/94

s/s

Diana E. Murphy
Chief Judge

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
THIRD DIVISION

Dianne L. Shea,
individually and as
trustee for the heirs
of Patrick Joseph Shea,

Civ. File No. 3-94-1173

Plaintiff,

v.

ORDER

Sidney Esensten; Jeffrey A. Arenson;
Family Medical Clinics, a Minnesota non-profit
corporation; and Medica, a Minnesota non profit
corporation,

Defendants.

This matter is before the Court upon Defendant Medica's Motion to Dismiss pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure. After full consideration of the submissions of the parties, and for the reasons stated following oral argument on this motion, the Court finds that the Plaintiff's claims against Medica are preempted under 29 U.S. C. § 1144(a), but that it is unclear from the facts now before the Court whether the Plaintiff could allege facts sufficient to support a Breach of a Fiduciary Duty claim under ERISA.

Accordingly, **IT IS HEREBY ORDERED** THAT:

Defendant Medica's Motion to Dismiss (Clerk Doc. No. 40) is GRANTED;

Plaintiff's State tort claims against Medica are DISMISSED WITH PREJUDICE, and

Plaintiff is given LEAVE UNTIL APRIL 28, 1995 TO AMEND her Complaint to include a Breach of a Fiduciary Duty Claim under ERISA.

Dated: April 22, 1995.

s/s
Paul A. Magnuson
United States District Court Judge

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
THIRD DIVISION

Dianne L. Shea,
individually and as
trustee for the heirs
of Patrick Joseph Shea;
individually and derivatively
on behalf of participants in the
Seagate Group Health Plan,

Civ. File No. 3-94-1173

Plaintiff,

v.

MEMORANDUM AND ORDER

Sidney Esensten; Jeffrey A.
Arenson; Family Medical
Clinic, P.A., n/k/a Fairview
Clinics, a Minnesota non-profit
corporation; and Medica, a
Minnesota non-profit corporation,

Defendants.

This matter is before the Court upon Defendant Medica's Motion to Dismiss the Plaintiff's claims brought under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* (ERISA), pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure. There are also two appeals from Magistrate Judge Lebedoff pending before this Court.

BACKGROUND

Plaintiff Dianne L. Shea, a resident of Minnesota, is the widow and personal representative of Patrick Joseph Shea. Defendant Dr. Sidney Esensten is a physician specializing in family practice. Defendant Dr. Jeffrey A. Arenson is a physician specializing in internal medicine. Defendant Family Medical Clinic (Clinic) is a non-profit health care provider. Dr. Esensten and Dr. Arenson practice medicine at the Clinic. Mr. Shea was employed by Seagate Technologies, Inc. (Seagate), or the company that preexisted Seagate, beginning in 1979. Seagate created the Seagate Group Health Plan. Defendant Medica contracted with the Seagate Group Health Plan to administer and provide health coverage to Mr. Shea and his family, and contracted with the Clinic to provide health care to its subscribers pursuant to a health maintenance organization (HMO). Mr. Shea enrolled in the Medica Primary coverage offered by the Seagate Plan.

Mr. Shea died of heart failure at age 40, survived by Mrs. Shea and two minor children. Mr. Shea's father had died of heart disease while in his mid-fifties. His mother had died from conditions that included heart disease while in her fifties. Mr. Shea had two half-brothers, both of whom suffered from heart disease and underwent coronary bypass surgery while in their early forties.

The Clinic treated Mr. Shea during the 1980's for an ulcer. Dr. Esensten was aware that Mr. Shea's parents had died of heart disease or related conditions and that Mr. Shea's half-brothers underwent bypass surgery in their early forties. Dr. Esensten administered an echocardiogram in July 1989, and tested Mr. Shea's cholesterol level in August 1989. Mr. Shea altered his diet to limit high cholesterol foods and began exercising. However, over several years, his cholesterol level continued to rise. Mr. Shea informed Dr. Esensten that he began experiencing tingling and shortness of breath, and

experienced dizzy spells. Dr. Esensten knew that Mr. Shea was smoking one and one-half packs of cigarettes per day. Dr. Esensten stated to Mr. Shea that his symptoms did not warrant referral to a cardiologist, but he recommended a cardiopulmonary examination.

In January 1992, Dr. Esensten again advised Mr. Shea that his cholesterol level was too high. Dr. Esensten referred Mr. Shea to Dr. Arenson, under whose care Mr. Shea performed a treadmill test. A June 1992 cholesterol test revealed Mr. Shea's cholesterol level remained high.

Also in June 1992, while on a trip to Thailand, Mr. Shea was admitted to the hospital on complaints of dizziness, tightness in his chest and difficulty breathing. Thai staff administered nitroglycerin, which relieved Mr. Shea. The staff also administered a stress test during which an electrocardiogram monitored Mr. Shea's heart. The test showed normal cardiac function with no indication of ischemic heart disease. During Mr. Shea's Thai hospitalization, Dr. Esensten was in contact with the treating Thai physicians. Mr. Shea quit smoking on June 30.

Upon his return to the United States, Mr. Shea scheduled an appointment with Dr. Esensten at the Clinic. Mr. and Mrs. Shea visited the Clinic on July 6, 8, 11, and 22, and on August 10 and 14 of 1994. On each occasion except July 11, they met with Dr. Esensten. During these meetings Mr. Shea complained of shortness of breath, recurrent dizziness, tingling in his extremities, hyperventilation, chest pains at least weekly in the area of his heart and continuous lower back pain. The Sheas informed Dr. Esensten they would pay for the cardiologist's services if insurance did not cover them, and asked whether an angioplasty was in order. Dr. Esensten advised that an angioplasty was not in order and advised that a cardiologist was not necessary. Dr. Esensten referred Mr. Shea to Dr. Arenson.

Mr. Shea visited Dr. Arenson on August 19, 1992. Dr. Arenson noted Mr. Shea's hospitalization and treatment in Thailand. Mr. Shea informed Dr. Arenson of constant pain in the lower quarter of his abdomen, and that he had experienced light-headedness and dizziness two weeks prior. Mr. Shea visited Dr. Arenson again on August 24, 1992. Mr. Shea informed Dr. Arenson that his abdominal pains continued. Dr. Arenson diagnosed the presence of a polyp and referred Mr. Shea for a colonoscopy at Fairview Riverside Hospital. The colonoscopy was performed on September 3, 1992, revealing a polyp 4 millimeters in diameter, 15 centimeters into the colon, and mild sigmoid diverticulosis.

Mr. Shea visited Dr. Arenson again on September 17, 1992. He informed Dr. Arenson of continued symptoms in his chest and hands. Dr. Arenson prescribed Xanax, a medication prescribed for digestive problems. At various times from August 30, 1989 through October 1992, Mr. Shea was prescribed the following medication: Zantac, Niosporin otic, Hismanal, Amoxillin, Mylanta, Mevacor, Flagyl, Lopid, Provachol, and Xanax.

Mr. Shea visited Dr. Arenson again October 6, 1992. Mr. Shea's cholesterol level remained high, but was marginally lower than it had been in June. W. Shea complained of sinus headaches and buzzing in his right ear. After that date, Mr. Shea experienced chest pains about once per week and continual lower back pain. He continued to experience regular tingling in his extremities and had spots on his feet. Mr. Shea had to sleep in an upright position.

Neither Dr. Esensten nor the Clinic referred Mr. Shea to a cardiologist. Mr. Shea was scheduled to perform another treadmill test on March 9, 1993.

On March 5, 1993, Mr. Shea experienced chest pains that extended down his arm. He left work early, intending to go to the Clinic. Mr. Shea did not arrive at the Clinic; he was found dead in his car at 9:00 p.m. that same day. An autopsy

revealed 80% stenosis of the left anterior descending coronary artery and 50% to 56% stenosis of the right coronary artery. It also revealed moderate right ventricular hypertrophy and dilation, and moderate pulmonary edema. The coronary arteries had mild to moderate arteriosclerotic changes at 4 centimeters from its origin.

Mrs. Shea brought this action in the State of Minnesota, Hennepin County District Court, in July 1994. The Defendants removed the action to this Court, and Mrs. Shea moved to remand to state court. Chief Judge Diana Murphy denied Mrs. Shea's motion to remand on October 17, 1994. In April 1995, this Court dismissed with prejudice Mrs. Shea's state tort claims against Defendant Medica, but gave leave for Mrs. Shea to amend her Complaint to include a breach of fiduciary duty claim under ERISA. Mrs. Shea filed an Amended Complaint alleging against Medica "Derivative Claims . . . under ERISA for Breach of Fiduciary Duty," "Direct ERISA Claims for Breach of Fiduciary Duty," and "Direct ERISA Claims for Arbitrary and Capricious Denial of Benefits." Medica now moves to dismiss all claims Mrs. Shea brings against it.

DISCUSSION

For the purposes of the Defendant's Motion to Dismiss, the Court takes all facts alleged in Plaintiff's Complaint as true. Westcott v. Omaha, 901 F.2d 1486, 1488 (8th Cir. 1990). Further, the Court must construe the allegations in the Complaint and reasonable inferences arising from the Complaint favorably to the Plaintiff. Morton v. Becker, 793 F.2d 185, 187 (8th Cir. 1986). A motion to dismiss will be granted only if "it appears beyond doubt that the Plaintiff can prove no set of facts which would entitle him to relief." Id.; see Conley v. Gibson, 355 U.S. 41, 45-46 (1957). Accordingly, the Court takes the preceding facts as alleged in

Mrs. Shea's Amended Complaint to be true for the purposes of Medica's motion.

Medica bases its Motion to Dismiss on several alternative grounds: (1) that Mrs. Shea lacks standing to bring an ERISA breach of fiduciary duty claim; (2) that Mrs. Shea has alleged no facts that indicate Medica breached its duties as a fiduciary; (3) that Mrs. Shea's claim for benefits violates this Court's Order granting her leave to amend her original Complaint; and (4) that the relief Mrs. Shea seeks is not available to her under ERISA. The Court need only address the first two bases, and does so in turn.

I. Standing to Bring ERISA Breach of Fiduciary Duty Claim

Medica argues Mrs. Shea lacks standing to bring a claim for breach of a fiduciary duty under ERISA. ERISA prohibits fiduciaries of ERISA-governed plans from breaching any of their "responsibilities, obligations, or duties." 29 U.S.C. § 1109(a). A fiduciary breaches its duty by misleading plan participants or misrepresenting the terms or administration of the plan. Anweiler v. American Electric Power Service Corp., 3 F.3d 986, 991 (7th Cir. 1993); Berlin v. Michigan Bell Telephone Co., 858 F.2d 1154, 1163 (6th Cir. 1988). Fiduciaries must also communicate material facts affecting a beneficiary's interests. Anweiler, 3 F.3d at 991; Rosen v. Hotel & Restaurant Employees & Bartenders Union, 637 F.2d 592, 599-600 (3d Cir.), *cert. denied,* 454 U.S. 898 (1981). The duty of a fiduciary to communicate material facts affecting a beneficiary's interests exists even if the beneficiary does not ask the fiduciary for the information. Anweiler, 3 F.3d at 991; Eddy v. Colonial Life Insurance Co., 919 F.2d 747, 750 (D.C. Cir. 1990).

ERISA allows a private action for breach of a fiduciary duty only if brought "by the Secretary, or by a participant,

beneficiary or fiduciary." 29 U.S.C. § 1132(a)(2). Medica argues Mrs. Shea is none of these. Mrs. Shea asserts that Mr. Shea was a "participant" of the plan and would continue to be one but for Medica's breach, and that she brings her ERISA breach of fiduciary duty claim not in her own right but as a representative of his estate.

Medica argues essentially that when Mr. Shea died he ceased to be a "participant" within the meaning of § 1132(a). Indeed, Medica quotes the plan's Certificate of Coverage No. 391 Section XXV as explaining, "Unless otherwise specified in the Contract, your coverage ends . . . [t]he date the subscriber's coverage ends, including death of the subscriber." Additionally, as Mrs. Shea admits, "At the time of this action [Mr. Shea] was deceased and was no longer a plan participant. . . . After [Mr. Shea's] death, [Mrs. Shea] did not elect to continue benefits under COBRA." Am. Compl. ¶ 75.

Medica asserts that "[b]oth [Mrs. Shea] and Mr. Shea had been terminated as members of the Seagate Plan on March 31, 1993." Medica's Mem. Supp. Mo. Dismiss at 7. Medica relies on a string of cases to support this position. It is well supported that an ERISA plaintiff must strictly be a participant or beneficiary, or otherwise fit within the limited list of plaintiffs as stated by 29 U.S.C. § 1132(a). Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134 (1985); Gilguist v. Becklin, 675 F.Supp. 1168 (D.Minn. 1987), *aff'd,* 871 F.2d 1093 (8th Cir. 1988); Zinn v. Donaldson Co., 799 F.Supp. 69 (D.Minn. 1992); Joseph v. New Orleans Electrical Pension & Retirement Plan, 754 F.2d 628 (5th Cir.), *cert. denied,* 474 U.S. 1006 (1985); Stanton v. Gulf Oil Corp., 792 F.2d 432 (4th Cir. 1986); Kuntz v. Reese, 785 F.2d 1410 (9th Cir.), *cert. denied,* 479 U.S. 916 (1986); Vilas v. Lyons, 702 F.Supp. 555 (D.Md. 1988). The cases clearly hold that a *former* plan participant simply is not a participant with standing to bring a breach of fiduciary claim under ERISA. Mrs. Shea's argument that "the word 'current'

nowhere appears in the statute or in the legislative history [defining participant]," Pl.'s Mem. Opp. Mo. Dismiss at 8, ignores the language of ERISA and the cases applying ERISA.

However, the cases Medica relies on that reject standing involve former participants or other persons who *voluntarily* terminated their rights under the plan. See Gilquist, 675 F. Supp. at 1170-71 (holding plaintiffs who voluntarily elected to withdraw from the plan and receive a lump-sum payment lacked standing); Zinn, 799 F.Supp. at 75 (holding the decedent's first wife who had entered an antenuptial agreement relinquishing marital property rights, and her children, all lacked standing under ERISA to claim breach of a fiduciary duty because they were not then nor could become beneficiaries under the decedent's profit sharing plan); Joseph, 754 F.2d at 630 (holding plaintiffs who reached retirement age and elected to receive a lump-sum retirement benefit in lieu of monthly benefits lacked standing to claim trustees of the plan breached their duties under ERISA); Stanton, 792 F.2d at 434-35 (holding plaintiff who retired and received benefits lacked standing to assert an ERISA breach of fiduciary duty claim where the fiduciary failed to inform the plaintiff of pending amendments to the plan that would have benefited the plaintiff had he postponed retirement); Kuntz, 785 F.2d at 1411 (holding that former employees who chose to receive vested benefits in a lump-sum were no longer plan participants and thus lacked standing to claim breach of fiduciary duty under ERISA); Vilas, 702 F.Supp. at 561-62 (holding a widow, who voluntarily waived her spousal rights to her husband's retirement benefits and whose husband had received a lump-sum payment of all his benefits before he died, lacked standing to bring a breach of fiduciary duty claim under ERISA).

Mrs. Shea claims that Mr. Shea, in whose stead she brings this action, would have remained a plan participant but

for Medica's breach of its fiduciary duty. Particularly, Mrs. Shea asserts that Medica imposed "specific financial incentives and disincentives" regarding the making of referrals to specialists that caused Drs. Esensten and Arenson, as well as the Clinic, to refuse to refer Mr. Shea to a cardiologist, and that Medica had a duty to disclose the Clinic's "financial incentive to reduce referrals." Am. Compl. ¶¶ 75-79. Mrs. Shea asserts that had Medica disclosed the alleged financial disincentives to cardiologist referral, Drs. Esensten and Arenson would have referred Mr. Shea to a cardiologist and he would have received the necessary life-saving treatment the Clinic did not provide. In other words, Mrs. Shea argues Medica's breach ultimately caused Mr. Shea's death and the consequent *involuntary* termination of his plan participation.

Assuming, as the Court must, the truth of the facts as alleged by Mrs. Shea, and construing inferences from those facts in Mrs. Shea's favor, the issue here is more narrow than Medica suggests, and one of apparent first impression. That is, does a plaintiff lack standing due to the fact he is no longer a plan participant where he would be a plan participant but for the fiduciary's allegedly violative conduct? At least in dicta the Eighth Circuit has recently answered this question:

> Several circuits have crafted an exception to the [present plan participation] requirement for cases in which, "but for the employer's conduct alleged to be in violation of ERISA," the employee or former employee would be a plan participant. Other circuits have declined to adopt this exception. *We apparently adopted it without discussing the issue* in Howe v. Varity Corp., 36 F.3d 746 (8th Cir. 1994).

Adamson v. Armco, Inc., 44 F.3d 650, 654-55 (8th Cir.)(emphasis added and internal citations omitted), *cert.*

denied, __ U.S. __ (1995). Medica attempted to distinguish Adamson at oral argument on this matter by asserting Adamson applies only to cases where the defendant takes affirmative steps to remove standing. However, the Adamson appellants had alleged a breach of fiduciary duty under ERISA on the basis that, *inter alia*, the fiduciary *failed* to inform participants the plans at issue were not funded. Id. at 654. The Court did not address the issue except in dicta as it held the plaintiffs voluntarily relinquished participation through their own inaction by allowing their claims to become time-barred. Similar to the allegations of the appellants in Adamson, Mrs. Shea alleges the fiduciary failed to inform Mr. Shea, a plan participant at the time, of material information concerning the plan — that Medica imposed structural financial disincentives to a referral that would have kept Mr. Shea both alive and a plan participant. Unlike Adamson, the inferences from Mrs. Shea's Amended Complaint do not suggest Mr. Shea voluntarily relinquished participation in the plan.

The Adamson statement does not appear so restricted as Medica suggests and Medica directs the Court to no contrary authority. Taking Medica's argument to its logical conclusion, Adamson would permit standing if a fiduciary actually lied to a participant and that lie induced the participant to end prematurely his plan participation; but would permit standing where a fiduciary instead intentionally misled a participant into ending prematurely his plan participation by simply withholding material information. As discussed above, however, under ERISA fiduciaries are required to communicate material facts affecting a beneficiary's interests even if the beneficiary does not ask the fiduciary for the information.

Applying Adamson to the facts as claimed here, the Court concludes Mrs. Shea has alleged that but for Medica's conduct in violation of ERISA Mr. Shea would have remained a plan

participant. Standing will not be avoided by Medica's alleged violative conduct that purportedly proximately caused the involuntary end to Mr. Shea's plan participation. Because of this holding the Court does not reach Mrs. Shea's "derivative" status argument except to state that she has provided no support for the application of Rule 23.1 of the Federal Rules of Civil Procedure to this matter, or that Mr. Shea "is an equitable plan 'shareholder'" under that Rule.

II. Breach of Fiduciary Duty

Medica first argues that it is not a fiduciary. Medica cites no authority except Mrs. Shea's purported failure to state facts sufficient to demonstrate that Medica is a fiduciary. However, Mrs. Shea's Amended Complaint alleges Medica contracted with the Seagate Group Health Plan to administer and provide health coverage to Mr. Shea and his family, and contracted with the Clinic to provide health care to its subscribers pursuant to a health maintenance organization (HMO). Additionally, she alleges Medica administered the plan and structured financial incentives and disincentives to control the referral process for plan participants. A fiduciary is one who "exercises any discretionary authority or . . . control respecting management of [the] plan or exercises any authority or control respecting management or disposition of its assets, . . . or . . . has any discretionary authority or discretionary responsibility in the administration of [the] plan." 29 U.S.C. § 1002(21)(A). Liberally construed, Mrs. Shea's Amended Complaint alleges facts sufficient to meet this definition.

Medica next asserts that the gist of Mrs. Shea's claim is physician malpractice, and that claims against HMOs based on physician malpractice do not implicate fiduciary duties under ERISA. In support, Medica relies on Kuhl v. Lincoln National Health Plan, 999 F.2d 298 (8th Cir. 1993), *cert*

denied, 114 S.Ct. 694 (1994). In Kuhl the Eighth Circuit affirmed the district court's refusal to permit a breach of a fiduciary duty claim under ERISA expressly because "monetary damages are not available under [29 U.S.C. § 1132(a)]," and the plaintiffs sought monetary damages instead of equitable relief. Id. at 304-5. Here, Mrs. Shea now seeks equitable relief for her claims against Medica. Thus, Kuhl does not support Medica's argument.

Similarly, Roen v. Massachusetts Mutual Life Insurance Co., No. 4-94-487 (D.Minn. Jan. 31, 1995), does not support Medica's position. In Roen, this Court held that the plaintiff's state claims of wrongful death and negligence were preempted by ERISA and did not fall within the ERISA saving clause exception. Additionally, the plaintiff in Roen stated that ERISA did not provide the relief the plaintiff sought. Id. at 8. The Court agreed that the factual allegations in the complaint failed to state a claim under ERISA. In that case a plan participant's son was evaluated by a psychologist who recommended in-patient chemical dependency treatment, but the corporation that had contracted with the insurance carrier to perform preadmission reviews approved only out-patient treatment. Within several days the participant's son committed suicide, and the trustee for his heirs and next of kin sued in his behalf for damages claiming the insurance carrier and the corporation performing preadmission reviews caused his death. Certainly those facts do not even suggest breach of a fiduciary duty. Roen is inapposite.

Rice v. Panchal, 875 F.Supp. 471 (N.D. Ill. 1994), also provides no support for Medica's position. The plaintiff in Rice sued his physician for malpractice and sued his ERISA health care plan under the state respondeat superior doctrine. Rice held that while the plaintiff's malpractice claim against his physician was viable in state court, ERISA preempted his

respondeat superior claim against the ERISA plan.[1] The court then considered whether the plaintiff had stated a claim against the plan under ERISA based on the facts of his preempted state respondeat superior claim. The court concluded that he had not because he did not expressly plead a breach of fiduciary duty under ERISA and on the added ground that such claims did not implicate the plan's fiduciary duties. Unlike Rice, the Plaintiff here has alleged a claim of breach of a fiduciary duty under ERISA; she has not simply alleged Medica is liable for the malpractice of the treating physicians under a respondeat superior theory.

Likewise, Nealy v. U.S. Healthcare HMO, 844 F.Supp. 966 (S.D.N.Y. 1994), does not support Medica's argument. After rejecting as preempted by ERISA the plaintiff's state claims, the Nealy court refused to construe the plaintiff's state breach of fiduciary duty claim as an ERISA breach of fiduciary duty claim. The court held that the breach claim was preempted because the plaintiff sought extra-contractual damages not benefiting the plan itself. Id. at 974. As in Rice, the Nealy court dismissed the plaintiff's state claim against the plan and remanded the plaintiff's malpractice claim brought against the treating physician to state court. Again, unlike the Nealy plaintiff, Mrs. Shea seeks equitable relief here.

Finally, the Court does not find Altieri v. Cigna Dental Health, Inc., 753 F.Supp. 61 (D.Conn. 1990), supportive of Medica. As with the other cases cited by Medica, Altieri does not involve an alleged failure to disclose material facts affecting the interests of beneficiaries. At least facially, this case does, and therefore Altieri is irrelevant to Mrs. Shea's breach of a fiduciary duty claim. While Mrs. Shea's Amended

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[1] After the parties submitted the present matter, on appeal the Seventh Circuit held that Rice plaintiff's respondeat superior claim did not fall within the complete preemption doctrine as it relates to federal jurisdiction, and remanded the case with instructions to the district court to dismiss the complaint for lack of jurisdiction. Rice v. Panchal, 65 F.3d 637 (7th Cir. 1995).

Complaint retains at its heart a claim of negligence against Mr. Shea's treating physicians, the Court finds that her fiduciary duty claim against Medica is based on facts sufficiently separate as not to constitute a mere restatement of her state negligence claim.

Medica next argues that it had no duty to disclose the information Mrs. Shea alleges it was required to disclose. It asserts that 29 U.S.C. §§ 1021-31 provide the exclusive disclosure requirements under ERISA, and that these sections do not require ERISA plans to provide the information about the financial relationship between the provider and the HMO that Mrs. Shea demands. As noted above, however, fiduciaries must communicate material facts affecting a beneficiary's interests. Anweiler, 3 F.3d at 991. The question then becomes, assuming the Eighth Circuit would follow this portion of Anweiler, was the alleged financial relationship between the plan and Mr. Shea's treating physicians the type of "material fact" the disclosure of which Anweiler demands?

The answer requires consideration of Anweiler and Rosen. In Rosen, the Third Circuit considered whether an insurance plan could deny the plaintiff benefits where it failed to notify him that his employer's contributions to the plan were in arrears and also failed to take action against the employer for continued refusal to contribute. The Rosen court reasoned from the principles of trust and held that the fiduciary insurance company breached its duty by neglecting to inform the plaintiff and other pensioners that their employer failed to make the contributions to the trust as required by the pension's language where that failure jeopardized their eligibility under the plan. Rosen, 637 F.2d at 599-600.

The Anweiler court considered whether the defendants breached a fiduciary duty by not informing the plan participant that a reimbursement agreement he signed was revocable. He had signed the reimbursement agreement at his

employer's request, and the agreement designated the defendant insurance company as the beneficiary of his group life insurance policy for any overpayment owed at his death resulting from double benefits from social security. After his death, the defendant insurance company was paid the overpayment. The plan participant's widow would have been the beneficiary but for the reimbursement agreement. She sued in his behalf, alleging breach of fiduciary duty, because her husband had not been informed that he was not required to sign the agreement in order to receive his long-term benefits and that the agreement was revocable at will.

From the Third Circuit's holding in Rosen, the Seventh Circuit in Anweiler concluded that "[f]iduciaries must . . . communicate facts affecting the interests of beneficiaries." Anweiler, 3 F.3d at 991. From this premise, Anweiler held that the defendants had a duty to give the plan participant full and complete material information concerning the reimbursement agreement at the time he was asked to sign it. Id. at 991-92. The court thus determined that the defendants breached their fiduciary duty under ERISA.

Despite the broad language of Anweiler, the Plaintiff here cites no authority, and the Court is aware of none, that suggests the "facts affecting the interests of beneficiaries" include the plan's payment procedures or policy where that policy might affect a physician's decision to provide care in a given way, or to refer a patient to a specialist. Taken to its logical conclusion, the Plaintiff's position would require ERISA health plans to disclose to each plan participant the details of each care-provider's payment process, including amounts paid to each physician for each service the physician provides, because every such detail might affect the physician's decision to provide care in one way or another, or whether to refer the patient. Anweiler does not support such a requirement. Indeed, the Plaintiff's position would permit dissatisfied plan participants to absorb a plan fiduciary into

medical malpractice claims against negligent physicians based solely on any perceived disparity in the plan's payment procedure. This is not the type of misleading omission concerning participation in the plan that the Anweiler court considered. It is also not the type of information concerning one's jeopardized status with the plan the Rosen court addressed. Additionally, the information sought here is all too obvious. One might presume without the aid of ERISA-mandated disclosure that physicians receive less compensation when they no longer provide care to a patient after referral. This type of "financial disincentive" to referral is not the type of "material fact" the disclosure of which Anweiler would require.

This holding precludes Mrs. Shea's ERISA claim against Medica, but leaves in tact her ability to pursue her malpractice claim based on the alleged negligence of Mr. Shea's physicians. Because of this finding, the Court need not address Medica's other bases in support of its motion, except to note that the Court considers the "Arbitrary and Capacious" claim of Count Five of the Amended Complaint, which is based on the same facts discussed here and which goes beyond this Court's Order granting leave to amend the Complaint, as subsumed by the Plaintiff's Breach of Fiduciary Duty Claim.

CONCLUSION

Mrs. Shea's claim against Medica should not fail for lack of standing because she brings the action as trustee for the heirs of Mr. Shea, and, as alleged, Mr. Shea would have remained a plan participant but for the defendants purported breach of fiduciary duty. Despite the opportunity to amend her Complaint, Mrs. Shea has failed to allege facts supporting her breach of fiduciary duty claim under ERISA against Medica; Medica had no duty to disclose details to plan

participants of its policy and procedures regarding payment to treating physicians under the facts of this case. There remain no federal questions for this Court, and no party asserts this Court has jurisdiction otherwise. Therefore, Mrs. Shea's claims against the other defendants should remain unprejudiced by this decision and actionable in state court. See 28 U.S.C. §§ 1367 and 1447(c).

Accordingly, **IT IS HEREBY ORDERED** THAT:

1. Medica's Motion to Dismiss Plaintiff's Breach of Fiduciary Duty Claims against Medica (Clerk Doc. No. 57) is GRANTED and the Plaintiff's claims against Medica are DISMISSED WITH PREJUDICE;
2. Because this Court now dismisses the only claim over which it has original jurisdiction, the Court declines to exercise its supplemental jurisdiction over the remaining state claims, and this case is therefore REMANDED to the state court from which it was removed, without costs;
3. The Clerk of Court shall MAIL A CERTIFIED COPY OF THIS ORDER to the Clerk of the Court of Hennepin County District Court, Minneapolis, Minnesota;
4. Medica's two appeals (Clerk Doc. Nos. 68 and 79) of Orders entered by Magistrate Judge Lebedoff are DENIED WITHOUT PREJUDICE AS MOOT.

LET JUDGMENT BE ENTERED ACCORDINGLY.

Dated: November 15, 1995.

s/s

Paul A. Magnuson
United States District Court Judge

UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

THIRD DIVISION

DIANNE L. SHEA, individually and as trustee for the heirs of Patrick Joseph Shea, decedent; individually and derivatively on behalf of participants in the Seagate Group Health Plan,

Civil No. 3-94-1173

Plaintiff,

NOTICE OF APPEAL

vs.

SIDNEY ESENSTEN; JEFFREY A. ARENSON; FAMILY MEDICAL CLINIC, P.A., n/k/a FAIRVIEW CLINICS, a Minnesota non-profit corporation; and **MEDICA**, a Minnesota non-profit corporation,

Defendants.

Notice is hereby given that Dianne Shea, in all of her various capacities listed above, as Plaintiff in the above named case, hereby appeals to the United States Court of Appeals for the Eighth Circuit from the final judgment of dismissal entered in this action on the 15th day of November 1995; from the Order of the District Court dismissing with prejudice all federal claims herein entered in this action on the

15th day of November, 1995; and from the order of the United States District Court denying Plaintiff's motion to remand entered in this action on the 14th day of October 1994.

Dated: November 28, 1995.

McGRANN SHEA FRANZEN CARNIVAL
STRAUGHN & LAMB, CHARTERED

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**ATTORNEYS FOR PLANTIFF/
APPELLANT DIANNE L. SHEA**

U. S. COURT OF APPEALS - EIGHTH CIRCUIT

Docket No. _____

APPELLANT'S FORM A
Appeal Information Form
To be filed with the Notice of Appeal

STYLE OF CASE:

DIANNE L. SHEA

Appellant[redacted]

vs.

SIDNEY ESENSTEN; JEFFREY A. ARENSON; FAMILY MEDICAL CLINIC, n/k/a FAIRVIEW CLINICS; and MEDICA,

[redacted] Appellee.

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DATE OF DISTRICT COURT JUDGMENT: 11/15/95

BASIS OF: DISTRICT COURT JURISDICTION: 29 U.S.C. §1144(a); 28 U.S.C. §1331
APPELLATE JURISDICTION: 28 U.S.C. §1291

JURISDICTIONAL ISSUE, IF ANY: N/A

IS THIS CASE SUITABLE FOR CONSIDERATION IN THIS COURT'S SETTLEMENT PROGRAM?
( ) Yes. (X) No. If no, state why: The court must resolve important legal issues of first impression that will determine, in tur whether and to what extent Plaintiff Appellant enjoys a cause of action.

APPROPRIATE STANDARD OF APPELLATE REVIEW:
De Novo

LIST ISSUES ON APPEAL: (List below and if necessary attach supplementary page.)
Optional--Include citations for each issue and in jury cases attach challenged instructions and trial memoranda.
DOES THIS CONSTITUTE YOUR STATEMENT OF ISSUES UNDER FRAP 10(b)(3)? (X) Yes. ( ) No.

1. Whether a fiduciary is required by ERISA to inform patients that it fines their doctor for referring the patient to a cardiologist and pays a bonus to their doctor for declining the same referral?

2. Whether ERISA preempts a state tort claim against an ERISA fiduciary for tortious interference with the doctor/patient relationship and for fraud?

Submitted by: [signature] 11/24/95
Signature Date

Copy 1 - White - Send to Appellee (together with an uncompleted Form B)
Copies 2 & 3 - Canary & Pink - Send to Clerk, Eighth Circuit Court of Appeals.
Copy 4 - Goldenrod - Retain

BEST AVAILABLE COPY

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 95-4029MN

Dianne L. Shea, individually and as trustee for the heirs of Patrick Joseph Shea, decedent; individually and derivatively on behalf of participants in the Seagate Group Health Plan,	*	
Appellant,	*	
v.	*	Appeal from the United States District Court for the District of Minnesota.
Sidney Esensten; Jeffrey A. Arenson; Family Medical Clinic, now known as Fairview Clinics, a Minnesota non-profit corporation; Medica, a Minnesota non-profit corporation,	*	
Appellees.	*	

Submitted: November 21, 1996

Filed: February 26, 1997

Before FAGG, WOLLMAN, and HANSEN, Circuit Judges.

FAGG, Circuit Judge.

After being hospitalized for severe chest pains during an overseas business trip, Patrick Shea made several visits to his long-time family doctor. During these visits, Mr. Shea discussed his extensive family history of heart disease, and indicated he was suffering from chest pains, shortness of breath, muscle tingling, and dizziness. Despite all the warning signs, Mr. Shea's doctor said a referral to a cardiologist was unnecessary. When Mr. Shea's symptoms did not improve, he offered to pay for the cardiologist himself. At that point, Mr. Shea's doctor persuaded Mr. Shea, who was then forty years old, that he was too young and did not have enough symptoms to justify a visit to a cardiologist. A few months later, Mr. Shea died of heart failure.

Mr. Shea had been an employee of Seagate Technologies, Inc. (Seagate) for many years. Seagate provided health care benefits to its employees by contracting with a health maintenance organization (HMO) known as Medica. As part of its managed care product, Medica required Seagate's employees to select one of Medica's authorized primary care doctors. Mr. Shea chose his family doctor, who was on Medica's list of preferred doctors. Under the terms of Medica's policy, Mr. Shea was insured for all of his medically necessary care, including cardiac care. Before Mr. Shea could see a specialist, however, Medica required Mr. Shea to get a written referral from his primary care doctor. Unknown to Mr. Shea, Medica's contracts with its preferred doctors created financial incentives that were designed to minimize referrals. Specifically, the primary care doctors were rewarded for not making covered referrals to specialists, and were docked a portion of their fees if they made too many. According to Mr. Shea's widow Dianne, if her husband would have known his doctor could earn a bonus for treating less, he would have disregarded his doctor's advice, sought a

cardiologist's opinion at his own expense, and would still be alive today.

Initially, Mrs. Shea brought a wrongful death action in Minnesota state court. Mrs. Shea alleged Medica's fraudulent nondisclosure and misrepresentation about its doctor incentive programs limited Mr. Shea's ability to make an informed choice about his life-saving health care. Medica removed the case to federal court, contending Mrs. Shea's tort claims were preempted by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1144 (1994). Mrs. Shea filed a motion to remand, but the district court denied the motion. Mrs. Shea then amended her complaint to assert Medica's behind-the-scenes efforts to reduce covered referrals violated Medica's fiduciary duties under ERISA. See id. §§ 1002(21), 1104(a)(1). Believing ERISA does not require an HMO to disclose its doctor compensation arrangements because they are not "material facts affecting a beneficiary's interests," the district court dismissed Mrs. Shea's amended complaint for failing to state a claim. See Fed. R. Civ. P. 12(b)(6). Mrs. Shea appeals. Having construed the pleaded facts in the light most favorable to Mrs. Shea, we reverse the judgment of the district court. See Alexander v. Peffer, 993 F.2d 1348, 1349 (8th Cir. 1993).

Because our removal jurisdiction is intertwined with the district court's preemption ruling, we must first consider whether ERISA displaces Mrs. Shea's tort claims against Medica. See Schroeder v. Phillips Petroleum Co., 970 F.2d 419, 420 (8th Cir. 1992) (per curiam). ERISA supersedes state laws insofar as they "relate to any employee benefit plan." 29 U.S.C. § 1144(a). To this end, the language of ERISA's preemption clause sweeps broadly, embracing common law causes of action if they have a connection with or a reference to an ERISA plan. See Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47-48 (1987). Here, Medica administered Seagate's employee benefit plan, and Mrs. Shea

maintains Medica wrongfully failed to disclose a major limitation on her husband's health care benefits. Along these lines, we have held that claims of misconduct against the administrator of an employer's health plan fall comfortably within ERISA's broad preemption provision. See Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc., 999 F.2d 298, 301-04 (8th Cir. 1993); see also Howe v. Varity Corp., 36 F.3d 746, 752-53 (8th Cir. 1994) (ERISA preempts state fraudulent misrepresentation claims), aff'd, 116 S. Ct. 1065 (1996).

After considering the factors that guide our inquiry, see Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc., 947 F.2d 1341, 1344-45 (8th Cir. 1991), we conclude the district court correctly decided that ERISA preempts Mrs. Shea's state-law claims. The outcome of Mrs. Shea's lawsuit would clearly affect how Seagate's ERISA-regulated benefit plan is administered, and if similar cases are brought in state courts across the country, ERISA plan administrators will inevitably be forced to tailor their plan disclosures to meet each state's unique requirements. This result would be at odds with Congress's intent to ensure "the nationally uniform administration of employee benefit plans. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S. Ct. 1671, 1677-78 (1995). Thus, we agree with the district court that Mrs. Shea's case was removable to federal court. See Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 63-64, 66-67 (1987) (ERISA preemption supports removal); Anderson v. Humana, Inc., 24 F.3d 889, 891 (7th Cir. 1994) (plan participant's attacks on HMO's incentive structure were both preempted and removable); Rodriguez v. Pacificare of Texas, Inc., 980 F.2d 1014, 1016-17 (5th Cir. 1993) (state-law claims based on HMO's refusal to provide referral letter were properly preempted and removed).

Having decided Mrs. Shea's case belongs in federal court, we turn to Medica's contention that Mrs. Shea lacks standing

to pursue an ERISA remedy. ERISA authorizes current plan participants to assert a claim for breach of fiduciary duty. See Adamson v. Armco, Inc., 44 F.3d 650, 654 (8th Cir.), cert. denied, 116 S. Ct. 85 (1995). According to Medica, Mr. Shea was no longer a Seagate plan participant after he died. See 29 U.S.C. § 1002(7). Contrary to Medica's view, we have held that if the fiduciary's alleged ERISA violation caused the former employee to lose plan participant status, the former employee will nonetheless have standing to challenge the fiduciary violation. See Adamson, 44 F.3d at 654-55; see also Swinney v. General Motors Corp., 46 F.3d 512, 518-19 (6th Cir. 1995); Vartanian v. Monsanto Co., 14 F.3d 697, 702 (1st Cir. 1994). Mrs. Shea contends that, but for Medica's failure to disclose Mr. Shea's doctor's financial stake in discouraging covered referrals to specialists, her husband would still be alive and a current plan participant. Stated another way, Mr. Shea did not voluntarily relinquish his rights in the Seagate plan. See Adamson, 44 F.3d at 655. We are persuaded that Mrs. Shea, as the representative of Mr. Shea's estate, has standing to assert her husband's ERISA claims. Any other result would reward Medica for giving its preferred doctors an incentive to make more money by delivering cheaper care to the detriment of patients like Mr. Shea, and "ERISA should not be construed to permit the fiduciary to circumvent [its] ERISA-imposed fiduciary duty in this manner." Swinney, 46 F.3d at 518-19; see also Varity Corp. v. Howe, 116 S. Ct. 1065, 1068 (1996) (former plan participants tricked by a breach of a fiduciary duty have standing to sue).

With the jurisdictional challenges out of the way, we next consider whether Medica had a duty to disclose its referral-discouraging approach to health care. ERISA requires plan fiduciaries to "discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries." 29 U.S.C. § 1104(a)(1). In addition to ERISA's express disclosure requirements, see 29 U.S.C. §§ 1021-1031,

"'Congress invoked the common law of trusts to define the general scope of [a fiduciary's] . . . responsibility.'" Varity Corp., 116 S. Ct. at 1070 (quoting H.R.Rep. No. 93-533, at 3-5, 11-13 (1973)). In affirming our decision in Varity Corp., the Supreme Court concluded that ERISA fiduciaries must comply with the common law duty of loyalty, which includes the obligation to deal fairly and honestly with all plan members. See id. at 1074-75. Although the Supreme Court found it unnecessary to reach the issue, our earlier opinion made clear that the duty of loyalty requires an ERISA fiduciary to communicate any material facts which could adversely affect a plan member's interests. See Varity Corp., 36 F.3d at 754. "The duty to disclose material information is the core of a fiduciary's responsibility, animating the common law of trusts long before the enactment of ERISA." Eddy v. Colonial Life Ins. Co. of Am., 919 F.2d 747, 750 (D.C. Cir. 1990).

Although the district court acknowledged Medica's duty of loyalty, the court felt the compensation arrangements between Medica and its doctors were not material facts requiring disclosure. We disagree. From the patient's point of view, a financial incentive scheme put in place to influence a treating doctor's referral practices when the patient needs specialized care is certainly a material piece of information. This kind of patient necessarily relies on the doctor's advice about treatment options, and the patient must know whether the advice is influenced by self-serving financial considerations created by the health insurance provider. The district court believed Seagate's employees already realized their doctors' pocketbooks would be adversely affected by making referrals to outside specialists. Even if the district court is right, Seagate's employees still would not have known their doctors were penalized for making too many referrals and could earn a bonus by skimping on specialized care. Thus, we conclude Mr. Shea had the right to know Medica

was offering financial incentives that could have colored his doctor's medical judgment about the urgency for a cardiac referral. Health care decisions involve matters of life and death, and an ERISA fiduciary has a duty to speak out if it "knows that silence might be harmful." Bixler v. Central Penn. Teamsters Health & Welfare Fund, 12 F.3d 1292, 1300 (3d Cir. 1993); see Restatement (Second) Of Trusts § 173 cmt. d (1959). Indeed, in this case the danger to the plan participant's well being was created by the fiduciary itself. If Mr. Shea had been aware of his doctor's financial stakes, he could have made a fully informed decision about whether to trust his doctor's recommendation that a cardiologist's examination was unnecessary.

In sum, we believe Mrs. Shea has stated a claim against Medica for breaching the fiduciary obligation to disclose all the material facts affecting her husband's health care interests. When an HMO's financial incentives discourage a treating doctor from providing essential health care referrals for conditions covered under the plan benefit structure, the incentives must be disclosed and the failure to do so is a breach of ERISA's fiduciary duties. We thus reverse the district court's order dismissing Mrs. Shea's amended complaint for failure to state a claim on which relief can be granted and remand the case to the district court for further proceedings. We decline Medica's invitation to consider several remedy-related issues that were not addressed in the district court's ruling.

A true copy.

Attest:

CLERK, U.S. COURT OF APPEALS,
EIGHTH CIRCUIT.

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 95-4029MNST

Dianne L. Shea, etc.,	*	
	*	
Appellant,	*	
	*	Order Denying Petition for
vs.	*	Rehearing and Suggestion
	*	for Rehearing En Banc
Sidney Esensten, et al. ,	*	
	*	
Appellees.	*	

The suggestion for rehearing en banc is denied. The petition for rehearing by the panel is also denied.

May 6, 1997

Order Entered at the Direction of the Court:

s/Michael E. Gans

Clerk, U.S. Court of Appeals, Eighth Circuit

STATUTORY PROVISIONS AT ISSUE

29 U.S.C. §§ 1144(a); 1144(b)(1),(2); 1144(c) (ERISA § 514)

> (a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.
>
> (b) (1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.
>
> (2) (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.
>
> (B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or

investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

***

(c) For the purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

29 U.S.C. § 1002(1) (ERISA § 3(1))

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the

extent that such plan, fund, or program was established or is maintained for the purpose of providing for the participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C. § 1132(a)(1) (ERISA § 502(a)(1))

A civil action may be brought --

(1) by a participant or beneficiary --

(A) for the relief provided for in subsection (c) of this section [governing Administrator's refusal to supply requested information], or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;